

# THE MEDICAL AND SURGICAL REPORTER.

No. 1868.

PHILADELPHIA, DECEMBER 17, 1892.

Vol. LXVII—No. 25

## Original Articles.

### OBJECT LESSONS IN GYNÆCOLOGY.

By W. H. LINK, A. M., M. D.,  
PETERSBURG, INDIANA.

#### III.

#### CONSERVATISM IN GYNÆCOLOGY.

In country practice, "conservatism" and ignorance are synonymous terms. In cities like New York or Philadelphia some, teachers even, are known who arrogate to themselves the title of "conservatives," and pose as beacon-lights warning the inexperienced to avoid the dangers of heroic procedures. Upon closer view these men are usually found to be awkward and clumsy surgeons whose mortality, when they do operate, is very high as compared with their more skillful competitors. In order to avoid invidious comparisons, they turn away from all surgery possible and seek to hide their incapacity behind a sonorous title. This title they hope may convey to the unwary or the weak, an idea of abstract superiority in themselves combined with a most laudable solicitation for the interests and the safety of their patients. Such a combination of qualities they are most unwilling to concede to any whose success impel them to a course which leaves timidity shivering in imaginary grave-yards; a course compelled by experience because it finds ignorance plodding along beaten paths, learning nothing from the fate of those confiding victims of false diagnosis or delayed therapy whose whitened sepulchers, like milestones, mark the progress of "conservatism" along its chosen road. If there is any one thing in medicine that we country doctors do know the height, depth, length and

breadth of, it is "conservatism" so mis-called. The word is dinned into our ears so much, held up before our eyes so often, that we sometimes suspect that one of its attributes will some day be found to be the long sought-for fourth dimension. Then our knowledge will be equaled only by our self-sufficiency, and he who foists anything new or bold upon us will be made to pay the penalty by having it first tried upon himself.

While we say that among us ignorance and "conservatism" are convertible terms, it must not be forgotten that there are two kinds of ignorance. When one makes every effort possible to keep in touch with the advanced thought and the most recent discoveries in the profession to which he belongs, and when his knowledge is only bounded by his opportunities, the severest tribunal extant will acquit him of the charge of culpable ignorance. Should his *conservatism* consist in standing by known truths and tried methods till better ones come his way, then the word in its meaning, lies very close to wisdom. The country doctor, living far away from the great centers of medical thought and often existing only as a tangent to the great circle of medical knowledge, cannot accept for himself crude and unsettled theories or methods not backed by a very great success. For this reason he is the only true *conservative*—holding fast to all that is good and shunning what time, opportunity and experience have shown to be evil. Pope's couplet on the use of words is his chosen motto: "Be not the first by whom the new is tried; nor yet the last to lay the old aside." His antithesis is one who, having eyes, sees not, and having ears, hears not the things with which genius or perseverance is daily enriching professional knowledge. To tell him of something new or striking is but casting pearls before

swine. Instead of accepting as a blessing or as tidings of great joy, some newer method of surgery or some improved theory or newly-discovered fact in medicine, he only intensifies the darkness of his own blindness and deepens the shadow of his own ignorance by decrying the newer light of his more progressive brethren. He at once becomes proud of his ignorance. The world of medicine and surgery in his eyes holds but two camps, the "conservatives" and the inexperienced. In the first belong himself and all, who, like him, look upon the science of medicine as a closed book which it would be sacrilege for any one to add to or take from. He silences criticism and confounds argument by his constant reference to *his experience*. The greatest truths may be daily set before him, but they fall on unheeding ears. In such a man the obstinacy of youth has become the stupidity of age, and opportunities which might have brought improvement "have passed away and left no shadow of their loveliness on the dead waste of life." Envy of his more progressive contemporaries fills his heart with bitterness; and when he writes he jips his pen in the ink of detraction; while, his cowardice alone forbidding him to identify the object of his malice, covert innuendo and weak insinuation sputter on his written page like feeble glimmers from an exhausted tallow dip.

*Conservatism* of the better kind; that is *conservatism* which waits till questions are no longer debatable, and holds fast to that which has proven good till something better appears to take its place, which looks to the experience of the great hospitals and the general consensus of opinion to settle doubtful subjects of discussion; is commendable among the great army of country practitioners.

For the very reason that we all look to the cities, their teachers and writers, as guide-boards along our great professional highway, they should point forward not backward. A guide-board pointing backward may show us the way over a very good road, but it is one that has been pressed by our weary feet so long that we need no direction to find our way. A teacher living in a great city, surrounded by hospitals and dispensaries, spurred on by the magnetism of emulation, must, if he would retain our confidence or merit our respect, be among the first to show us the

excellence of any new procedure, or of any great truth which has suddenly assumed proportions of importance. When individuals so situated fall behind and begin to rehash old and abandoned methods, because their skill is unequal to the task of grasping with the new, great damage is done among men who accept their teachings. It is so much easier for everybody to go along as they have been accustomed always to do, than it is to learn and practice something new. Thus the old iodine, glycerine, hot douche, opium, poultice and tampons, are still prevalent in the hands of country doctors and the obstinately "conservative" city practitioners who whitewash the vaginal vault with a variety of medicaments for the cure of the various forms of tubal disease. Such a line of treatment being even yet set forth in most of the latest text-books. And men who have foisted upon the profession weak and puerile literature are daily adding to the mischief wrought by their books by filling the journals with a lot of the same kind of diluted nonsense. The honestly *conservative* or conscientious country doctor, reading both sides, is "betwixt the devil and the deep sea" until self-enlightened by his own experience. But while he hesitates his patients are lost. To illustrate the evil effects of bad literature and false "conservatism," I shall give a few short histories of the evils of delay, bad therapy, incorrect diagnosis, and mistaken pathology, as they have occurred within the last ten years in this county and as they have come under the observation of either my preceptor, Dr. Byers, or myself.

CASE I. Mrs. B., married, mother of 4 children. Had an attack of pain in bowels, followed by complete obstruction. Dr. B., the attending physician, and at that time the leading practitioner of the county, diagnosed concealed hernia, gave a fatal prognosis, and called for counsel. Dr. B—r., an able physician from a neighboring county, was called. He concurred in the diagnosis and treatment, which under the "conservative" teaching of the time, was opium, fluid diet and rest. Fæcal vomiting supervened and, after lingering for more than a week, the patient died. At the post-mortem it was found that a knuckle of intestine had fallen through a tear in the broad ligament and, becoming strangulated, had produced all

the symptoms complained of, and been followed by death. The hernia was easily reduced at the post-mortem and the gut was not gangrenous. By a timely section she could have been saved. The bowel could have been lifted out, the rent in the ligament sewed up and the patient been left in as good condition as before. The diagnosis was arrived at by exclusion and was brilliant enough to satisfy the most critical; but the influence of the text-book lore, the absence, at the time, of any positive literature advocating the practice of abdominal section, led both of these physicians along the "conservative" track and a useful life was lost.

CASE II. Mrs. H., mother of a large family of girls. Had suffered for a long time with pelvic abscess. She finally became very sick and the attending physician informed the family that if the pus burst into the bowel she would get well, otherwise not. At last the collection on one side did open into the bowel and she became better; but soon the abscess on the other side grew worse than before, and again the only hope held out was, that it might open into the bowel. But instead, it opened into the peritoneal cavity and she died in a few hours. This case offered a most brilliant opportunity for good surgery. Double pyosalpinx with ovarian abscess. But at that time such operations were not known out in the country. The teachings of Tait had not yet penetrated the back-woods, and the eminent men, who now so ably set forth the science of abdominal surgery in this country, had not yet found their voices. The men who furnished the literature for country doctors to read and ponder, prided themselves on being great head-lights of "conservatism" and taught that all abdominal work was necessarily fatal unless done in their private hospitals, while their statistics showed that most of it done there was equally fatal. Joseph Price, with his 123 sections done in courts and alleys and over livery stables, WITH BUT ONE DEATH,—had not yet knocked the wind out of the self-inflated gas bags who had been for years flooding the market with padded text-books and advertising private hospitals for abdominal work.

CASE III. Was called in counsel, very early in my career as a physician, to see a lady, Mrs. T., 30 years old, mother of three children. Found her, as the attend-

ing physician said, suffering from peritonitis. She had great pain in the pelvis, a very sore belly, a high temperature and a very rapid and feeble pulse. She would not permit a digital examination because she said, "it hurt her so much she could not stand it." We had no trouble to decide that she had "idiopathic" peritonitis and that she needed stimulants and plenty of opium. It took a large amount of the drug to keep her quiet but we did not reach the limit of Alonzo Clark by a good deal. She kept growing worse for three days when she died. This, in the light that I now have, was a case of tubal disease with leakage and resulting peritonitis. A section would have saved her, but "conservatism" let her die. I do not feel culpable, for we acted according to the latest text-books; and the literature in the journals, that threw any light on the subject at that time, was scarce indeed. Whenever any man, a little in advance of the rest, did advocate surgical measures for the relief of such cases a dozen old fogies lifted up their voices in favor of hot water, opium, and such other tinkering palliations, until the country doctor was perforce, led to believe that the surgeons were veritable Jack the Rippers with mutilation only as the end of their efforts and the result of their work.

CASE IV. O. L., girl; 16 years old; in the practice of Dr. H., attacked with sudden pain in bowels which rapidly developed into a well marked case of peritonitis of the "idiopathic" variety. Opium, diet, and rest were prescribed, together with stupes to the surface of the abdomen, with the usual "conservative" result—death. The doctor says that, with the light he now has, he is enabled to say that she had an attack of peritonitis due to appendicitis, and that a section would have saved her. But the old "conservative" teaching of both books and journals and from lecture rostrums in various medical schools, was thundering against anything like boldness especially in the country doctor who had no *private hospital*.

Just here, although not gynecological cases, I may with propriety quote the results of a few cases of appendicitis in men, because the subject comes under the head of abdominal surgery and gynecology without abdominal surgery becomes nothing more than vagina-swabbing. There have been four deaths from appendicitis,

within the last six years, in this county. Every one of these cases was a good subject for surgery and all were sent to death by the old opium, poultice, do nothing plan. This state of affairs is to some extent yet going on, not only in this county but in every other county in this state, and I have no reason to believe that Indiana is behind other states in the scientific knowledge, boldness and skill of her medical men. People are dying by the thousand and for want of the timely application of surgical means, and in view of this I wish to close with the statement I made at the end of lesson II: "There are too many operations by the few and too few by the many."

#### REPORT OF TWO CASES OF NEPHRECTOMY—RECOVERY.\*

By LEWIS G. NOLTE, M. D.,  
MILWAUKEE.

Surgery of the kidney has always been a subject of interest, but more especially during the last two decades. It has been of interest because during that time more has been done than ever before to elaborate plans of diagnosis in diseases of the kidney, especially for diseases of an inflammatory and suppurative character, and, if necessary, extirpation of this organ, when found diseased in such a way that radical means were called for. It was our own surgeon, Dr. Wolcott, now deceased, who first extirpated the kidney; but he did not know that he had removed it until after the operation. He had extirpated the kidney with a cancerous mass, unknown to himself until afterwards. The patient died on the fifteenth day.

The operation nephrectomy was, however, first resorted to intentionally by Simon, of Heidelberg, in 1869. From that time until 1884, when Weir, of New York City, published an able review in the *New York Medical Journal* entitled: "Extirpation of the Kidney," one hundred and fifty-two cases of nephrectomy had been reported.† Since then so many cases have been reported that it may be

said that the operation is no longer a rare one. Nephrotomy is still more frequently performed; probably because less difficult. Still, I am sure, the two cases I report will be of interest.

CASE I. P. R., aged thirty-three; M; United States; carpenter; family history excellent.

Although a carpenter by trade he had been doing the duties of shipping-clerk in a stove concern for the last seven years. Had always been well and, indeed, very strong until five years ago when he began to suffer pain in left side and loin. He noticed that he was losing flesh and strength but continued to work. As time rolled by he had to pass his water more frequently than usual until finally it became an annoyance to him. The urine became cloudy and ill-smelling; never had noticed any "gravel;" never had cystitis, or gonorrhœa, or any other venereal disease. He continued in this way until in the middle of June, 1889, he was taken down permanently, when, he states, he had lost at least forty pounds. He had been treated for lumbago, indigestion and lastly for typhoid fever with peritonitis. His urine had never been examined, he said. His last physician had treated him until a few days before I saw him, and his last explanation was that *the typhoid fever had settled in his left kidney.*

I was called to see him September 7, 1889.

When I first saw patient he was in bed. He looked very pale, emaciated and anxious. He complained very loudly of pain even when quiet, although he tossed about a good deal on account of it, for he was delirious at times. His temperature was 104° F.; pulse 128 and feeble; tongue furred, brown and dry. I was informed, that although almost three months had elapsed since he had to go to bed, he had hardly slept any. He was indeed in a "typhoid condition." but it was not typhoid fever. There were besides symptoms of typhoid fever, others both objective and subjective.

He had had for some time past pain with, but more especially after, micturition. There also had been a frequent desire to micturate. The urine was described to me as having been, and being now, pungent and cloudy; very little was passed at a time. He had had diarrhœa

\*Read before the Milwaukee Medical Society, November 8, 1892.

†Weir, extirpation of the kidney—*New York Medical Journal*, No. 26, Vol. XL.

until three weeks ago, since which time he has been absolutely without any movement from his bowels. When he had the afore-mentioned diarrhoeal movements he would at times, not always, experience great pain in the abdomen, radiating from the left loin. At other times he had pains, described as dull and gnawing in character, always referred to the region of his left kidney and radiating therefrom. On examination I found left thigh well-flexed on pelvis; could not be extended without pain. The abdomen was moderately distended and tympanitic all over except toward the left loin where there was dullness. Abdomen was somewhat sensitive to pressure. In the left lumbar region there was considerable bulging, in fact, so much of a tumor that one could not help noticing it. It seemed to fluctuate.

In view of the fact that there were such clear indications of an inflammatory disease or the result of it—abscess, I did not hesitate one moment to insert an aspirating needle. The point of the needle had gone in about two inches, however, before any pus was drawn into the aspirator. Of course, the presence of pus settled the diagnosis, or, better, the means of getting rid of the pus. I at once decided to perform nephrotomy, or, if necessary, nephrectomy. The patient was very weak and anything that was to be done had to be done soon. So it was decided to operate next day although Sunday.

Operation: The patient was weaker than ever, having spent a bad and restless night, pain having been very severe. Temperature 103° F.; pulse 130 and feeble. He was in a pitiable condition indeed. It was decided to go ahead, however, and do what we could even if nothing more than a puncture of the abscess-sac resulted.

Ether was administered after patient had received a copious draught of brandy. I made an incision almost four inches in length, beginning about three inches from spinous process and immediately below the last rib and going outward and downward towards the crest of the ilium. The incision was right over the tumor. Every vessel was tied immediately, so as to keep the field clear of forceps. After severing muscles and fascia we came to the abscess wall, which I punctured once more with the

aspirator needle and upon reassurance laid it wide open. Fully one and a half pints of very offensive, green pus flowed from the wound, exposing a large cavity to view. After irrigation one could recognize broken down kidney tissue and structure in the cavity. Little remained besides sac-wall (capsule) and inflammatory debris.

The patient continuing to behave pretty well, it was decided to remove the remaining kidney tissue and capsule. The deeper incisions were extended so as to conform with the length of the superficial one. In doing this I was guided entirely by the sense of touch. It was certainly interesting to examine this wound. I could very easily feel the lower edge of the tenth rib, the colon and the diaphragm. After much work and anxiety I managed to remove what there was left of the kidney, but it was piecemeal work on account of the fact that the kidney had extended well up under the ribs. Hæmorrhage was moderate. The stump was tied with braided silk and the ends left long for future extraction. As the stump was short I caught the distal side of the ligature with a large forcip-pressure forceps and holding thus both pedicle and its ligature, it was left. Two smaller vessels were secured with hæmostatic forceps, but could not be tied conveniently, so they were left *in situ*. During the whole operation moderate pressure was made on the abdomen so as to force the bottom of the cavity nearer to the back. This was also done during the packing of the cavity with iodoform gauze. The wound was left wide open. This was done so as to be prepared, in case of hæmorrhage, to at once get at the vessels.

The patient rallied fairly well. Hot bottles had been employed throughout the operation and were continued for some time after. Brandy injections were frequently made. The patient was removed to his bed with the greatest care, lest we should disturb the forceps left in the wound, and for the same reason we kept him bolstered left side up.

When I called in the evening I found the dressing pretty well soaked with blood, but I was informed that what blood could be seen had shown itself within two hours after the operation, and had not increased any since. It was fully eight hours after the operation when I called,

and I therefore decided to leave the dressing undisturbed, all the more so because his condition was fair. At midnight he was the same; no more hæmorrhage. He merely complained of some smarting in the wound, the pain he had complained of before the operation had left him entirely.

Next day: Temperature 101° F.; pulse 100, of fair strength. Outside dressing changed; wound was left undisturbed. Had passed no urine; but I drew off about 2 ozs. with a catheter.

After this he passed urine himself. It increased in quantity. I did not measure it again. For the next three days the dressing was not disturbed, as the patient was doing well and the temperature was declining. As he still had some vesical uneasiness I began giving on the third day, 5 grains of benzoic acid three times a day, which seemed to do him good. On the tenth day I removed gauze packing and the forceps; irrigated the cavity and renewed gauze packing. Temperature was now 99° F; pulse 80. After this nothing eventful took place except that the ligature came away on the 20th day. All this time the packing was growing less, as the cavity contracted.

Patient was discharged cured after five weeks. Urine at time of discharge contained but few pus cells (probably from bladder), otherwise it was normal.

Three months after I had occasion to treat him for a wound of the leg and obtained some urine for examination. It was perfectly normal. He did not know how much he weighed now but he stated that he thought that he had regained all the flesh he had lost. At the time of his discharge I advised him to forever abstain from alcoholic beverages of all kinds and to drink as much milk as possible. I saw him at intervals for about two years and he continued well. He is well and living now.

CASE II. A. T., æt. 20; U. S.; unmarried; upholsterer; family history—mother had died of consumption.

He had been ill during the winter of '90-'91; thought he had influenza. From the description of the ailment, I think he had influenza, but whether this had any thing to do with the trouble under consideration I cannot say. I was first consulted on March 3d, '91, and at that time he was suffering from an attack of subacute bronchitis. This soon disappeared upon

treatment. He told me at this time that he had been treated for spinal trouble after the attack of influenza, and again for lumbago. After the bronchitis subsided he was by no means well. He continued to fail. He complained of pain in his back. It was an indefinite, dull pain. I examined his urine and found pus and albumen. He was pale, emaciated and nervous, and had been, as he was now, suffering from night sweats. I put him on a well-regulated milk diet in addition to other easily digested foods. Still he failed in strength and weight. That he had some kidney lesion was certain, but in what form I was unable to say. In June of the same year he came to my office and said he had pain in his penis and left testicle, besides a well-defined pain, dull in character on the left side of his back. He also said that he had to pass his water oftener than usual, and had on one occasion passed some clots of blood. On examination I found distinct pain on pressure on the left side over the kidney. I could detect no swelling through the abdominal walls or in the loin. I forgot to mention that he also complained of a moderate diarrhoea. Examination of urine revealed clots and shreds, albumen and pus. Did not examine for bacilli of tuberculosis. But from his antecedents and his general condition, I made up my mind that he had tuberculosis of the kidney. I told him that we would have to operate on him with the result that he remained away from my office.

On October 2, 1891, he returned to my office telling me that he had been waiting for me (I had been away on a six weeks vacation), and that since he had been to my office last he had noticed an enlargement in his left loin, and had considerable pain there. On examination I found a fullness where he had indicated it. There was pain on pressure, no fluctuation that I could obtain. The exploring needle brought forth pus after three attempts to obtain it. Operation was advised and was performed the next day.

Operation:—Just before the operation he called my attention to his left elbow, where he had a swelling which I made out as tuberculosis of the joint. Ether was administered. Incision was made pretty nearly as in Case I. only about one inch longer, and the kidney was soon reached.

The capsule was opened and several ounces of liquid pus flowed therefrom. The capsule was now torn wide open and it was found that the whole organ was one large caseous mass; it was much larger than the normal kidney should be. The caseous mass was easily removed in spite of its large dimensions and the pedicle tied. There was no hæmorrhage of consequence. The skin and muscles were united with catgut and silk sutures in the upper part, the lower half being left open for packing and drainage. He rallied quickly and made a rapid and uneventful recovery, except that a small sinus persisted for over two months in spite of iodoform bougies, etc. It finally closed. He passed water as usual the day after the operation and never had trouble with it thereafter. His diarrhoea ceased; probably due to the fact that he was confined to bed and to morphine given for the pain. A few days after the operation I treated his elbow with iodoform injections and continued to do so for some weeks after, and he did fairly well, but he never regained complete use of the joint. I advised resection of the joint and was denied the privilege of operating. I did not persist, for I expected more trouble. I did not see him after his fistula had healed, although I recommended constitutional treatment. He walked about and did fairly well, however.

In the spring of 1892 he called and was found to be pretty well advanced in pulmonary phthisis. He said he merely wanted to know what ailed him and wanted no treatment as he knew he would soon die. He died a few weeks later. Autopsy denied. The joint had become somewhat larger, but he had had no renal symptoms from the time of operation to the time of his demise.

I have looked extensively into the literature on the subject of nephrectomy and as there is now such a mass of it, I will only draw conclusions and give them here.

I have found, that in a general way, operators prefer the lumbar operation for suppurative diseases of the kidney on account of the advantage for drainage, and the avoidance of opening the peritoneum and thus infecting it. Many prefer to do nephrotomy preparatory to nephrectomy. Lange, of New York, says he now prefers to do the whole operation at one sitting, because he has found that patients do not

gain anything by waiting, and besides the operator has cicatricial tissue to contend with in a secondary operation. Gerster says he has not made up his mind yet which is the better plan. Briddon, of New York, prefers the primary operation.

Large tumors of the kidney should be taken out through the abdomen. Drainage can be established through the back before or after the major operation, when the kidney is removed through the anterior abdominal walls.

The incision may be made posteriorly from the last rib to the crest of the ilium near the edge of the erector spinæ. Some prefer to resect or remove one to two ribs, twelfth and eleventh, when deemed necessary. Others caution against this procedure as the pleura sometimes extends down to the last rib, and has been wounded in operations of this kind. Some operators add a transverse incision to the vertical one, when more room is needed. Wyeth makes use of an oblique incision.

When it has been decided to operate through the peritoneum (anteriorly) the majority prefer the incision made through the linea semi-lunaris (Lateral Laparonephrectomy); others prefer the median incision (Laparo-nephrectomy), which is made just as in ovariectomy.

In a general way it may be stated that the lumbar operation presents more favorable statistics than the ventral. In cases of suppurative lesions of the kidney especially, in which it may be decided to operate anteriorly "cysto-entorrhaphy" should always precede opening of the sac.

*Note.*—In the first case the ligature disappeared, nothing of the stump came away. Patient well. In the second case, patient also complained of diarrhoea.

#### FISSURES OF THE TONGUE.

The following (*Le Bulletin médical*, is praised:

|   |                    |             |
|---|--------------------|-------------|
| R | Carbolic acid..... | 2.5 grams.  |
|   | Tr. iodine.....    | aa          |
|   | Glycerine.....     | 12.5 grams. |

#### MOUTH WASH.

In an article on the mouth as a focus of infection for various diseases, MILLER highly recommends the following as an aseptic mouth wash:

|   |                       |        |
|---|-----------------------|--------|
| R | Benzolic acid.....    | 5 i    |
|   | Tinct. eucalypti..... | 5 v    |
|   | Absolute alcohol..... | ℥iv    |
|   | Ol. menth. pip.....   | gtt. x |

—*Brooklyn Medical Journal.*

# Clinical Lecture.

## BUFFALO GENERAL HOSPITAL SURGICAL CLINIC.\*

PROF. ROSWELL PARK.

### EPITHELIOMA OF JAW, INJURY TO SKULL, CYSTIC TUMOR OF BREAST WITH POSSIBLE MALIGNANT ELEMENT.

I have talked to you very often about malignant growths, and have referred to the question of justifiability of operation and the clear understanding which ought to exist between patient and surgeon as to the risk of operation. This patient who presents an aggravated form of malignant trouble I have brought before you to illustrate how determined some men are to take the chances of operation rather than to discuss the prognostic and pathological features of their cases, which are quite plain. Seventeen years ago, this man had a little growth—presumably an epithelioma—removed from the lip. He was free from any manifestation of malignant disease till a little over a year ago when a growth about the size of a pea was noticed on the neck and was shortly afterward excised. This I interpret to have been an infected lymph-node which had become adherent to the skin and was beginning to break down. A couple of months ago the trouble returned and was again removed. Since then it has recurred and it has been treated once or twice with cancer pastes. On still further recurrence of the trouble he went to the same man who applied the paste and was told that it was too late for a repetition of that treatment since anything which would eat out the cancer would eat out the artery also and that an operation would not be advisable on account of the danger of hæmorrhage from the carotid artery or the jugular vein. His trouble has been getting worse all the time and last night he went to his regular physician and told him that he was going somewhere for operation and the doctor kindly brought him to me.

Here is a man of fifty, on the lower part of whose face you can see a large tumor, ulcerating on the surface. There is no question as to the diagnosis—it is an epithelioma—but only as to its extent. It

extends beneath the floor of the mouth and, though it may not be attached to the larynx, it is very close to it and is probably attached to the hyoid bone. It is firmly adherent to both the upper and the lower jaw and there is ulceration about the alveolar process. It lies closely upon the carotid sheath. I have spent nearly half an hour in the vain attempt to convince this man of the futility of operation. I have told him that a thorough removal of the growth is practically impossible and that if it were possible, there would be so much loss of substance from the operation that I could not bring the edges of the wound together. I have explained to him that an operation which was not thorough would excite a renewed activity on the part of the cancer cells and would, therefore, be worse than useless. I have warned him that he might die on the table and that, in any case, the operation would result in his death and I have told him that I did not want to act as his executioner. Even after all this has been said, he insists that he wishes the tumor operated on. Sometimes we find a case in which there is an excellent prospect for an early operation and after exhausting all our eloquence we can not induce the patient to submit to an operation. Here we see an instance of an equal determination under exactly opposite circumstances. If this patient had come to me two months ago, I might have advised operation as a matter of temporary relief. Now I can only advise him against operation. I have told him that I would not operate for a few days under any circumstances and have gotten him to promise to go home and make his will and talk the matter over with his family. If after all this, he still insists on operation, I have told him that I will consider the question again but I doubt whether it would be justifiable to operate under any circumstances. It certainly would not be unless I had given him to understand clearly about the gravity of his case. I have been accused of being too blunt in talking to patients about the dangers of operation but you can judge if it would be right for me to fail to let patients realize plainly what they may expect both from such a course and from the unmolested course of their trouble.

Yesterday there was brought into the hospital a young Polish lad who had been

\*Reported by A. L. Benedict, A. M., M. D.

injured three or four days ago by a locomotive. There is a rather uncertain lesion of the brain and I have not yet been able to make a positive diagnosis. Yesterday he was unconscious and when he was disturbed or when I pressed about the wound on his head, he would cry as he does now but with this difference that yesterday he made no articulate sound, whereas to-day he realizes to some extent what I am doing and replies with some intelligence. The question yesterday, as well as to-day was, whether the case demanded operation. It certainly was not a case of marked compression of the brain. The bodily functions were performed well, his pupils were of the same size though somewhat contracted on account of the morphine which had been given to control his restlessness. He moved all his extremities and their movement is even freer this morning. I have had his head shaved since I last saw him and you can plainly make out the scalp-wounds, one on the fore-head, the other over the right parietal bone. There is some ecchymosis about his right eye but there is not sub-conjunctival hæmorrhage, as there probably would be if there had been a fracture of the skull, resulting from the working forward of blood along the optic sheath. There is discoloration of the back of the head extending well down into the cervical region. The temperature has not been high. This morning it is 100.5°. After spraying out the scalp-wound with hydrogen-peroxide and carefully disinfecting my finger, I insert it into the wound and find no irregularity of bone. The finger is the best possible probe for making such an investigation. As there is no indication of serious trouble within the skull, I will put back the iodoform compress, over the wound, give symptomatic treatment and be ready to interfere if necessary. My conclusion is that the boy is suffering from concussion of the brain and possibly some minute hæmorrhages which would carry the case over into the category of contusion. It is quite likely that there has been a fracture but I do not pretend to say where. If, in two or three days from now, there should supervene compression symptoms, you know that the interpretation would be meningitis with pressure from pus. I should explore the wound, trephine and wash out the suppurating localities. This complication, however, I do not anticipate.

This patient, a woman of sixty, has a condition of considerable interest in a diagnostic way. In the breast she has a tumor and the question arises first, as to whether it is benign or malignant, and second, as to what is best to do for it. About two years ago, she noticed a little nodule in the breast and this has slowly enlarged and there is the history also that, several months ago, she was struck in the breast by her drunken husband. Here is a breast very much deformed by whatever the condition may be, the excess of deformity being of rather recent development. I want you to note that the nipple is retracted, that the tumor is lobulated, and that at two or three points there appear glistening surfaces almost like soap bubbles. There are little pouches that fluctuate just underneath the skin, and if firm pressure were made over them, they probably would break. After the first injury by her husband, the little lump enlarged to the size of a hen's egg, and since the second injury, about two months ago, there has been a very rapid increase. The tumor appears to protrude at two or three points just beneath the skin. So far, I have not been able to find any enlarged lymph nodes in the axilla. Perhaps we should first consider whether this is an abscess or some cystic disease. Now, it would be possible to have an acute abscess develop at any time in the breast with or without a co-existing tumor, either benign or malignant. But we may dismiss the suspicion of acute abscess as the signs of inflammation are not marked enough and the only abscess which would have so long a duration as this growth has had, would be a tubercular one, while none of the indications of tuberculosis are present here. My opinion, given tentatively and subject to modification on examination of the excised tumor, is that there was a cystic disease of the breast into which hæmorrhage has taken place at the time of the blows, and I expect to find altered blood in the mass. The patient's age makes us suspicious of cancer and it is quite possible that there is a somewhat recently developed co-existent cancerous condition. I can scarcely imagine a cancer of the breast of three years' duration, occupying as much of the breast as this does, with which we should not find enlarged axillary lymph-nodes and also in which we should not find the breast more fixed than this. This

breast is easily movable over the pectoral fascia and although there may be some adhesions, it is not glued to the fascia as is the case in well marked malignant disease. We must bear in mind, however, the fact that a tumor in the breast of a woman of almost any age, although benign in its beginning, may undergo malignant degeneration. It is possible to have a tumor which, at one spot, is cystic and innocent, while in other places, scirrhus or round-cell infiltration is occurring. Whatever the exact microscopic condition, therefore, you will readily understand the necessity for operation. This is not a case to be left alone, it is not one to be treated simply by evacuating the contents of the little cysts and allowing the wounds to heal, it must be attacked radically, and the breast must be excised. If the condition is not essentially malignant, the prognosis is excellent; if it be malignant there is every probability of prolonging life. The retraction of the nipple which you see here is not necessarily an indication of malignancy. Here the nipple could scarcely be otherwise than retracted on account of the enlargement of the breast around it.

If the case is malignant, I shall not want to save any more tissue than is necessary to close the wound. If, on the other hand, it is benign, it is better to save as much as necessary of the overlying skin.

In operating, therefore, I shall take time to dissect the skin from the growth beneath and, then, if the appearance of the tumor is suggestive of malignancy, more skin can be sacrificed. As soon as the knife penetrates the skin, an abundance of altered blood comes out, showing that there has been a hæmorrhage from the blows received. On examining the mass removed, I find, at one point, very hard tissue, here at the base there is a little pus and anteriorly a multilocular cyst. The hard portion does not offer as much resistance to the knife as would most scirrhus cancers, but seems more like inflammatory infiltration. This breast, though presenting no positive evidence of malignancy, presents a far worse appearance than do the majority of cases of cancer. It is a lesson to us not to judge too hastily from the external appearance. I am not quite satisfied that there is no malignant trouble and I, therefore, extend the incision toward the

axilla in order to search for lymph-nodes. Now I find, deeply situated, a number of nodes so enlarged as to afford a suspicion of cancerous infection and this makes it necessary to clean out the axilla. To be sure the presence of pus in the mammary structure might account for this lymphatic involvement; but it is much better for the woman to have this operation thoroughly done *now*, than to have to subject her to a second operation later.

## Communications.

### TREATMENT OF HEMORRHOIDS.\*

By JOHN B. DEEVER, M. D.

In opening the discussion upon the treatment of hemorrhoids I will confine the few remarks I have to make to what I consider the most essential points. And first a word as to the formation of this form of tumor and its varieties.

To understand the origin of piles we must be familiar with the arrangement of the veins of the rectum. The hemorrhoidal veins number three—the superior, middle, and inferior. The superior empty into the portal system, while the middle and inferior empty into the general venous system. In the upper part of the rectum they are arranged longitudinally, while below they are arranged circularly in the shape of a plexus, the hemorrhoidal veins are destitute of valves. Owing to the office of the rectum and to the erect position, these veins are very liable to become dilated and varicose.

To speak of a dilated and varicose condition of the veins in themselves constituting a hemorrhoid is a mistake. The first step in the formation of a hemorrhoid is a dilated and varicose condition of the veins, I admit, but, in addition to this condition of the veins there must be associated with it inflammatory exudate.

Hemorrhoids are divided into three varieties—external, internal, and intero-external. Hemorrhoids which protrude at stool, and are capable of being replaced and retained within the sphincter are of the internal variety, while hemorrhoidal tumors situated outside of the sphincter which cannot be forced inside are of the external variety. The intero-external

\*Read before Phila. Co. Med. Society, November, 23, 1892.

variety is a combination of the external and the internal. This variety occupies the verge of the anus, and is covered by both mucous membrane and skin.

The internal hemorrhoid is a varicose and dilated condition of the superior hemorrhoidal veins, therefore an affection of the portal system. The external hemorrhoid is a like condition of the middle and inferior hemorrhoidal veins, therefore an affection of the general venous system.

In the intero-external variety both sets of veins are involved.

External hemorrhoids are met in any one of three different forms. The first is simply a venous tumor, the result of a phlebitis and consequent thrombosis of a varicose vein; the second, a tumor composed of dilated and varicose veins with proliferation of the surrounding connective tissue; the third, a tumor made up almost entirely of proliferated connective tissue.

Internal hemorrhoids are met with as one of two forms: the capillary and the venous. The capillary hemorrhoid is composed of the terminal branches of the arteries and veins and intervening capillaries. It is this form of hemorrhoid which bleeds upon the slightest irritation; its surface, too, is granular, and presents somewhat the appearance of a strawberry. The venous hemorrhoid is made up of anastomosing veins and connective tissue; this I regard as but an advanced stage of the capillary hemorrhoid.

The treatment of hemorrhoids is palliative and radical.

Concerning the **PALLIATIVE** treatment I will have but little to say other than that I regard having the bowels move daily, and observing the strictest cleanliness, the two most important indications to be fulfilled. Doubtless, in some instances one or other of the various astringent ointments, so commonly used, may be, of some advantage, yet, I have little faith in their accomplishing a cure.

Before recommending radical treatment, the case is first to be thoroughly examined to determine whether such a procedure is justifiable.

Hemorrhoids may be symptomatic of visceral disease, of structural changes in the wall of the rectum above the pile-bearing area, such as carcinoma, stricture, etc. Under these circumstances the proper

treatment would be the correction, if possible, of the condition giving rise to the hemorrhoids. Again, they are often secondary to disease of the uterus, the bladder—as when a calculus is present—an enlarged prostate or a stricture of the urethra, etc.

In advising radical treatment a careful examination should be made first to determine whether any of the previously mentioned conditions are present or not. The urine is to be carefully examined, when, if albumen is present and dependent upon heart or kidney affection of a serious character, operation is to be strongly advised against.

**THE RADICAL TREATMENT OF EXTERNAL HEMORRHOIDS.**—In the first form, that of the venous tumor, the result of a phlebitis, thrombosis, etc., it will suffice to incise the tumor freely, and turn out the clot, after which the wound is to be packed gently, and thus favor healing from the bottom. In the second variety, that of dilated and varicose veins with proliferation of the neighboring connective tissue, it will often suffice to stretch the sphincter muscles, when, if this fails, I strongly recommend removal of the tumor with the clamp and cautery; in the third variety of external pile I also use the clamp and cautery. In either of the two latter varieties, when the tumors assume considerable size, it may not be possible to engage them individually in the clamp; under these circumstances they should be bisected, as it were, and each half clamped, the redundant portion cut away, and the pedicle canterized. It is in this variety of pile, when involving the entire circumference of the anus, that the Whitehead operation is applicable, but so far as my observation goes it does not offer any advantages over the clamp and cautery. When the external pile presents itself in the shape of a tab of skin it will suffice to remove it with a pair of scissors; in the event of bleeding following, it can usually be checked by the application of a wad of styptic cotton, over which is placed a compress and bandage, or the bleeding-point may be touched with the point of the cautery. In the second and third forms of external pile, if inflamed, tense, and painful, I think it much more satisfactory to etherize the patient and remove them at once, and not attempt to reduce the in-

flammation by the application of lead-water, laudanum, poultices, etc. I have found this a much quicker way to dispose of them, and at the same time less painful to the patient.

**OPERATIONS FOR INTERNAL HEMORRHOIDS.**—In few departments of surgery have there been more operations devised for the cure of any one condition than that of internal hemorrhoids.

The following is a list of the most important which have been advocated:

Excision; removal with wire *écraseur*; injection with carbolic acid or an astringent; the application of acids; removal by the galvanic cautery wire; dilatation of the sphincter muscles; clamp and cautery; crushing-ligature and Whitehead's operation.

Of these, I have had experience with the clamp and cautery, ligature, injection of carbolic acid, Whitehead's, and dilatation of the sphincter muscles. I now, however, rarely do any other than the clamp and cautery.

The advantages which the clamp and cautery possess over all other procedures is its universal application. The instruments required to perform this operation are a Smith's clamp and a pair of pile forceps, a pair of scissors, and a Paquelin's cautery. A tenaculum or vulsellum may be used in place of pile forceps.

The first step in the operation is the dilatation of the sphincter, which is followed by protrusion of the piles. The piles are now grasped with the forceps and the clamp adjusted. With the scissors the pile is trimmed down, leaving a pedicle one-quarter of an inch in length above the clamp. With the cautery iron at a dull-red heat the pedicle is reduced one-half-presenting a charred and dry surface. The clamp is now removed and the edges of the stump allowed to fold in. By leaving a pedicle as described, bleeding cannot follow the removal of the clamp. In cases, where the pile-surface is muco-cutaneous before the clamp is adjusted the skin should be divided with a pair of scissors, thus eliminating pain and subsequent contraction. The operation is completed by the introduction of an opium suppository, dusting the surface with iodoform, and the application of an antiseptic dressing. The after-treatment consists of rest in bed, light diet, and of the administration

of one-quarter of a grain opium pill night and morning for from three to four days, when the bowels are moved by a laxative and an enema given when the desire to defecate is felt. After this the patient is allowed the freedom of the room.

The advantages of this operation are freedom from hæmorrhage, the rapidity with which it is performed, the absence of pain in the majority of cases, the absence of retention of urine, and the patient's being able to resume his or her occupation ordinarily in from one week to ten days. Pain, irritability of the bladder, and prolonged convalescence occur in neurotic subjects. Further, I believe tetanus is less likely to follow this than any of the other operative procedures.

The objections to the ligature are the pain which follows the tying of the pile, retention of urine, the amount of blood lost in debilitated subjects, and the prolonged convalescence consequent upon the process of separation of the ligatures.

The objections urged against the injection of hemorrhoids are the liability of sloughing and fistula, the formation of abscess, the possibility of a diffused inflammation with pyæmia, an extension of the inflammation to the peritoneum, and embolism. While injecting a pile the base should be constricted until coagulation takes place, to prevent an embolus from being carried into the circulation.

The objections to the Whitehead's operation are the time required for its performance, the amount of blood lost, and the danger of the stitches cutting out, leaving a circular granulating surface which may result in atresia of the rectum. Again, it is only applicable in a comparatively small number of cases.

Dilatation of the sphincter muscles, like the Whitehead operation, is only applicable in a few cases, especially those of recent origin, and in the case of prolapsed hemorrhoids which are prevented from repositing themselves on account of being grasped by the sphincters. In the former instance it may suffice to bring about a cure if proliferation has not taken place to any extent, which is always questionable. In the latter case it can only offer a palliative means. When internal hemorrhoids become strangulated and gangrenous, they should at once be removed, preferably with the clamp and cautery.

# THE TREATMENT OF ISCHIO-RECTAL ABSCESS AND FISTULA-IN-ANO.\*

By HENRY R. WHARTON, M. D.

I have been requested to say a few words this evening on the treatment of ischio-rectal abscess and fistula-in-ano to open the discussion upon these subjects by the members of this Society.

**TREATMENT OF ISCHIO-RECTAL ABSCESS.**—In this form of abscess the purulent matter occupies the loose cellular tissue of the ischio-rectal fossa in close relation to the rectum, and from the anatomical peculiarities of the tissue in which it is situated it is apt to burrow widely and, if left to itself, to open into the rectum or through the skin into the region of the anus, and result in the production of one or other forms of fistula-in-ano, either the complete form or the external incomplete form of this affection.

To obviate this unfortunate result the prompt treatment of ischio-rectal abscess is urgently demanded, and I am decidedly of the opinion that attempts at abortive treatment of this form of abscess are worse than useless, that by such treatment valuable time is lost, and the surgeon has finally to resort to surgical treatment after extensive burrowing of pus has occurred with possibly perforation of the wall of the rectum.

It is, and has been for a long time, a surgical axiom that an ischio-rectal abscess should be opened promptly, and if so treated the probability of a fistula-in-ano resulting is much diminished. I formerly was satisfied to open these abscesses by a small incision, evacuate the pus, and in many cases a prompt recovery took place without the formation of a fistula, but in others a fistula resulted; whether the rectal communication was present at time of opening or resulted from the imperfect drainage secured by a small incision I am unable to say, but I am sure that the results I have obtained in these cases during the last few years since I have adopted Mr. Allingham's method of dealing with these abscesses have been much more satisfactory. By this method of treatment, even in cases where I have been able to demonstrate a rectal communication at

the time of the operation, I have secured healing without the formation of a permanent fistula. Therefore, in any case of inflammation of the tissue of the ischio-rectal fossa, whether the evidence of abscess be clearly demonstrated or not, I follow the method which is recommended by Mr. Allingham, which consists in etherizing the patient and placing him in the lithotomy position, after having located the position of the indurated tissue or abscess; and a rectal examination by means of the finger will often assist in locating the position of the abscess. A free incision, several inches in length, is made through the tissue, outside of and parallel with the fibers of the external sphincter muscle, and the incision is gradually deepened until the pus cavity is reached. It is then slit up to the length of the skin incision and the cavity is explored with the finger, breaking down any loculi which tend to divide up the abscess cavity, and so make one cavity. The cavity of the abscess is next washed out with a 1:2000 bichloride of mercury or 1:60 carbolic acid solution and is then packed with strips of iodoform gauze, and a pad of the same gauze is placed over the wound, and over this a pad of bichloride of mercury cotton is laid, and the dressing is secured in position by a T-bandage. An opium suppository is introduced into the rectum and the bowels are kept quiet for three or four days.

The dressing is not removed for two or three days, and at this time the packing is usually loose and can be removed without difficulty; after its removal the cavity is injected with peroxide of hydrogen; it is then irrigated with a 1:2000 bichloride of mercury solution; next the cavity is lightly packed with strips of iodoform gauze and the wound is covered with a pad of iodoform gauze and bichloride cotton. The same steps are observed at subsequent dressings, which are made at intervals of two or three days. The cavity usually heals rapidly by granulation and contraction, and in a few weeks it is completely healed.

Mr. Allingham recommends that the cavity be packed with lint saturated with carbolic oil, and I have employed this material, but now prefer to use the iodoform gauze, as I stated above.

I will report briefly a case in which this treatment was adopted. In January of

\*Read Phila. Co. Med. Society, November 23, 1892.

this year I saw, with Dr. Musser, a lady, forty years of age, who had suffered for a few days with inflammation of the tissues of the ischio-rectal fossa. On examination of the case I found the left buttock for a distance of six or eight inches from the very verge of the anus, indurated, hot, and painful; no soft spot of pointing could be detected. An examination of the rectum showed bulging of the walls of the rectum in the left side, and upon withdrawing the finger a small amount of pus escaped from the anus. The patient also stated that some matter had been discharged from the rectum during the day. The patient was etherized and a curved incision four inches in length was made just outside of the line of the sphincter muscle. This was gradually deepened until the cavity of the abscess was opened and a free discharge of many ounces of pus followed. On introducing my finger I found that the cavity extended laterally for some distance and passed upward between the wall of the rectum and the sacrum. In fact, with my two fingers introduced to their full length in the wound I could not reach the upper portion of the abscess cavity. A careful examination failed to reveal the position of the opening into the rectum. The abscess cavity was thoroughly irrigated with a 1:2000 bichloride of mercury solution, then packed with strips of iodoform gauze and a pad of gauze and bichloride cotton was placed over the external wound and held in place by a T-bandage. The patient did well after the operation. The cavity was dressed in the same manner very second or third day for the first two weeks, and at less frequent intervals after this time for six weeks, at which time healing was complete.

There is no question in my mind that there existed a communication between the abscess cavity and the rectum before the operation, as was shown by the discharge from the wound about a week after the operation of a piece of bone a little larger than a grain of corn. This bone, Dr. Harrison Allen examined for me and pronounced it to be a portion of a transverse process of a sheep's vertebra. It had been swallowed with the food, had ulcerated through the wall of the rectum, and had set up inflammatory action in the peri-rectal cellular tissue, terminating in this extensive abscess.

The points in the treatment of ischio-rectal abscess I would especially call attention to are: Early and free incision; thorough breaking down of any secondary cavities into one cavity; irrigation of the cavity with peroxide of hydrogen and a 1:2000 bichloride of mercury solution or 1:60 carbolic acid solution; packing with iodoform gauze and subsequent dressings made in the same manner, care being taken not to pack the cavity too firmly. Following this form of treatment the results of this variety of abscess in my hands have been most satisfactory.

**TREATMENT OF FISTULA-IN-ANO.**—Ball classifies fistula-in-ano as *complete* rectal fistula, in which there is a sinus leading from the rectum to some point in the skin in the region of the anus; and the *incomplete* fistula he describes as *internal rectal sinus*,—a sinus passing from the rectum into the peri-rectal cellular tissue; *external rectal sinus*,—one having an opening on the skin passing into the cellular tissue around the rectum, but not perforating the wall of the gut.

As regards the treatment of fistula-in-ano, the fact should not be lost sight of that it is possible to have a fistula-in-ano heal under simple treatment without operative interference. This is more apt to occur in recently formed fistulae, but as the result of palliative treatment is always uncertain in these cases, and a long course of local applications is required, this method of treatment is not generally adopted. Allingham says that he has had twenty-one successful cases under this method of treatment, and a number of cases in which he was unable to effect a cure after prolonged treatment. When this form of treatment is adopted it consists in trying to obliterate the fistulous track by rest, free drainage, and the local use of stimulating applications such as carbolic acid, nitrate of silver, and sulphate of copper. Rest to the part is best secured by the wearing of a firm anal pad secured by a T-bandage.

At the present time the most widely adopted and successful treatment of complete fistula-in-ano is by incision. The patient is etherized and placed on his side or in the lithotomy position, a probe-pointed flexible director is then passed through the external opening of the fistula and conducted into the rectum; the finger is then passed through the anus until it

comes in contact with the end of the director, which is bent and brought out of the anus; the tissues on the director are then divided with a scalpel or by means of scissors, care being taken to see that the division of the fibres of the sphincter muscle is made at a right angle to the course of the muscular fibers; oblique divisions of the muscle do not heal well and are apt to be followed by a loss of power in the muscle. The main track of the fistula being slit up, it is next explored for the presence of branching sinuses, and if these are found they are slit on a director. In indurated sinuses it is often well to make an incision through the base of the sinus, which seems in many cases to facilitate the healing. If the cutaneous edge of the fistula or sinuses tend to overlap each other near the anus they should be trimmed off with scissors. The surface of the exposed fistula or sinuses is next freshened with a curette, and after being washed out with a 1:2000 bichloride of mercury solution the cavities are packed with strips of iodoform gauze or lint saturated with carbolyzed oil. A compress of gauze is next applied over the wound, and over this is placed a pad of bichloride cotton, and the dressing is held in place by means of a T-bandage. The patient is given an opium suppository, and the bowels are kept quiet for three or four days.

The after-treatment of fistula-in-ano is most important, and many unfavorable results are due to carelessness in this particular. On removal of the primary dressing, at the end of two or three days, the sinus should be washed out with peroxide of hydrogen and a 1:2000 bichloride of mercury solution, and a strip of iodoform gauze should be lightly passed to the bottom of the wound and allowed to rest between its edges. The mistake is often made in packing these wounds forcibly, which interferes with healing. A piece of gauze and a pad of cotton is next applied over the wound and is held in place by a T-bandage. The patient should be kept on his back two or three weeks, and the wound should be dressed in the manner described daily or on alternate days, and at the end of three or four weeks healing is usually completed.

In cases of fistula-in-ano of the horse-shoe variety, one division only of the external sphincter muscle should be made,

and the branching sinuses should be laid open by curved incisions passing parallel with and outside of the line of the muscle. Sinuses extending to the perineum or buttock should be freely laid open.

The treatment of incomplete fistula of the external variety, or of external rectal sinus, consists in passing a director into the sinus down to the rectum, and if on passing the finger into the rectum, it is found that the director is separated only from the finger by the mucous membrane, and its position is low down in the rectum, it is better to push the director into the bowel and bring it out at the anus and divide the tissues as in complete fistula, and treat the resulting wound as described after the operation for complete fistula. If, on the other hand, the rectum is merely exposed at the bottom of the sinus, it is well to lay the sinus freely open to this point, curette its surface and pack it lightly with iodoform gauze. Subsequent dressings should be carefully made and the sinus will usually heal, though the course of treatment usually extends over a longer period of time than in cases where the sphincter muscle has been divided.

In internal incomplete fistula, or internal rectal sinus, when the rectal perforation is low down, a bent director should be passed into the anus, and its point should be passed through the rectal opening and made to project on the skin near the anus. This is cut down upon and exposed and the director is pressed through it, making the fistula a complete one, and the tissues on the director are divided. The subsequent steps of the operation and dressing are similar to those mentioned in the cases previously described.

When the rectal opening is high up and it is considered inadvisable to divide the sphincter muscle or the bowel to its full extent, a director should be passed through the internal opening and the surgeon should cut down on its point from an incision through the skin a little outside of the sphincter muscle. When it has been exposed the sinus or cavity should be curetted and irrigated and dressed with iodoform gauze, and by careful dressing the wound may be made to heal from the bottom, the rectal communications being shut off by granulation and subsequent contraction.

Among various methods of treating fistula-in-ano should be mentioned the

elastic ligature and the treatment by excision.

The elastic ligature is principally used in those cases in which the fistula opens into the rectum at a high point, where division by the knife would be accompanied by free hemorrhage. When employed, a cord of india-rubber one-sixteenth of an inch in diameter is threaded to an eyed-probe which is passed through the cutaneous opening into the rectum and brought out at the anus; before tying the ligature, the skin and mucous membrane to the edge of the anus should be divided so that the ligature can bury itself when tied, thereby saving the patient pain and at the same time facilitating the more rapid division of the tissues by the ligature. After the ligature has cut its way through the tissues it is often found necessary to dress the wound in the same manner as in cases where incision has been practised, to secure satisfactory healing.

The treatment of fistula-in-ano by excision has been recommended by some surgeons. The fistulous track being dissected out, the parts are brought together by deep sutures, and if primary union is obtained there is a great saving in the time of treatment. The form of fistula to which this method of treatment is best suited is the complete fistulæ which are not very deep and have a straight course; branching fistulæ, and ones very deeply situated, I do not think are favorable cases for this procedure. If in using this method of treatment it is found that primary union has not occurred, as shown by the escape of a little pus from the line of the incision, the sutures should be removed and the edges of the wound should be separated, and it should be lightly packed and treated—in fact, as a case in which primary incision had been practised.

As fistula-in-ano often occurs in patients suffering from phthisis, the question of the advisability of operating upon these cases often must be considered. The rule in these cases is to operate unless the patient's disease is in a very advanced state when no repair could be likely to take place. In the majority of phthisical cases the result of the operation is satisfactory.

The only serious complication following the operation for fistula-in-ano is incontinence of feces, and this is fortunately a rare complication. It may be guarded

against by care in dividing the sphincter muscle only at one point, and by seeing that the division of the muscle is not an oblique one. When incontinence exists, it may be relieved in many cases by excision of the cicatrix in the sphincter muscle and by suturing the freshened ends of the muscle together by catgut sutures, or by applying a point of Paquelin's cautery to the cicatrix or to several points of the mucous membrane and skin of the anal margin.

#### RUPTURE OF BICEPS—INFLUENCE OF THE MENTAL STATE OVER THE FŒTUS.

By JNO. M. CURRIER, M. D.  
NEWPORT, VT.

A case was presented to me a few days ago that was new to me. It was a rupture of the fleshy part of the right biceps muscle from the tendon of insertion. I have seen many cases of rupture of tendons from their insertions or origins but never before one of this character.

Mr. J., a farmer, aged about fifty-five years, three weeks previously, was lifting some logs with a lever, and on making an extra exertion felt something snap in his right arm which disabled him. The arm continued lame until I was consulted. At the examination I placed a weight in the right hand, the elbow being bent at right angles, and directed him to raise the weight; while making the attempt, the belly of the biceps could be felt contracting and the severed end of the muscle roll up and recede from my finger. On placing my finger on the tendon and its insertion, when an attempt was made to raise the weight, no motion, nor tension were felt. All the soreness was felt at the lower part of the belly of the muscle. The treatment in such a case consisted in keeping the elbow flexed and supported at right angles; pressure upon the belly of the muscle be kept up constantly with a concave splint, to produce extension of the muscle, until union takes place. No attempt should be made to lift the hand nor move the arm.

A case has recently come under my observation which illustrates in a remarkable degree, the influence of the state of the mother's mind over the nutrition of the

child in utero. Anna R., aged nine years, was recently attacked with whooping cough; when examining the case I learned the following early history. Ever since her birth she has had what the parents termed a "heart trouble." I found a loud systolic murmur, very distinct over all the region of the heart, and very much louder over, and to the right of, the sternum. The pulse were feeble at the wrist, but regular. The child had always been anæmic, tiring easily, and always unable to endure much exertion. While the mother was carrying the child (about the third month) she sent the oldest child down to build a fire in the kitchen stove, in preparation for dinner. When she thought the oven was sufficiently hot the mother came down into the kitchen to commence dinner. She heard a low moaning noise like some one in distress, and on opening the oven door out came the pet cat, that had been imprisoned therein, nearly lifeless. It soon died. This scene made a great impression upon the mother's mind, which she did not fully recover from for several days. Pregnancy went on as usual after recovery from the shock. At birth and ever since the child was feeble. The children born before and since this one were healthy and robust. Since the birth of this child the parents have been busy picking up instances of children deformed from the mothers' fright during pregnancy. This seems to be a case where only the heart was arrested in its development by the state of the mind of the mother.

### Society Reports.

#### OBSTETRICAL SOCIETY OF PHILADELPHIA.

*Meeting of December 1st, 1892.*

THE PRESIDENT, Dr. W. H. H. Githens, in the chair.

DR. EDWARD P. DAVIS presented a case of PELVIC HÆMATOCELE TREATED BY ABDOMINAL SECTION AND GAUZE DRAINAGE.

The patient married at seventeen and gave birth to a living child after a normal labor. Two months afterward she had a discharge of blood from the genital tract which continued for two months. Four

years ago she became pregnant a second time but aborted. She recovered from this abortion and menstruated regularly till February 13, 1892, when she was seized with sudden pain, syncope and vomiting. When seen by the writer, six weeks after this, she complained of pain across the abdomen, of a bearing down sensation with a feeling of weight in the pelvis. An examination showed the uterus slightly enlarged and retroverted. A tumor of semi-solid consistence filled the lower portion of the pelvis and into this the uterus was merged. The uterus seemed to be part of the tumor and it was thought that a fibro-cystic tumor of the uterus or an ectopic gestation might be present. When the abdomen was opened, bloody fluid welled up from the right half of the pelvis. This fluid contained small clots of jelly-like consistency; the fluid and clots being the color commonly seen in hæmatocele. The fluid was found to have filled a sac situated behind the right broad ligament and extending downward into Douglas' cul-de-sac. It was without odor and no evidences of peritonitis or intestinal adhesions were present. No rupture of the fallopian tube could be found nor was the ovary apparently abnormal. The fluid was removed by sponging and the sac tamponed with iodoform gauze, the end of the gauze being brought out at the lower end of the incision. The patient's convalescence was normal, the gauze being removed several inches at a time.

After the operation her menstruation returned, regularly and painlessly, until early in September, when she again missed it for six weeks, and complained of pain and weight in the pelvis which was followed by flooding and the discharge of clots and material similar to that which had been expelled at a previous abortion. At that time she did not come under the notice of the writer but desired early in October an operation for closure of a laceration of the pelvic floor to correct a cystocele and rectocele of moderate extent. At this time she considered herself in the early weeks of pregnancy. On examination it was found that a condition of affairs similar to that which had formerly existed was present on the left side of the patient's pelvis, namely the uterus retroverted and a tumor of semi-solid consistence projecting into the cavity of the pelvis. The pelvic floor was closed, the patient making an uninterrupted recovery.

Whether this pregnancy is ectopic or intra-uterine is a possible question. The patient while not a bleeder, presents a remarkable tendency to hæmorrhage. It is the purpose of the writer to keep her under observation until the existence of intra-uterine pregnancy can be demonstrated or denied. If such be present, the effort will be made to prolong the pregnancy till a living child can be secured. If the pregnancy is not intra-uterine, and the pelvic tumor increases in size, there will be ground for considering the patient pregnant ectopically and this condition will demand appropriate treatment.

DR. CHARLES P. NOBLE reported a  
CASE OF SUCCESSFUL ELECTIVE CÆSAREAN SECTION.

It was done for the relative indication and was elective in that, it being determined in the latter weeks of pregnancy that the delivery of a living child by the natural passages was impossible, the Cæsarean operation was decided upon and done during the last week of gestation but before the onset of labor. The reporter stated that the advantages of the operation, done before the onset of labor, are obvious as here we have a perfectly well ordered section in place of a hurried operation with the drawbacks of hasty preparations, perhaps strange assistants, bad light and faulty asepsis in some part of the technique. The danger of hæmorrhage from the failure of the uterus to contract properly in operations done before labor is purely theoretical and, excepting those cases where the uterus was paralyzed by the unnecessary practice of constricting it with rubber tubing, there was only one case on record where contraction did not take place.

The classical rather than the Porro operation was done, because the operator did not believe it proper, without grave reasons, to deprive a woman of the child-bearing function. The Porro operation should be limited to cases of fibroid tumors or those unfortunate cases where the operator has been called in late, after the patient has been long in labor and the danger of uterine atony and infection of the birth canal are present.

The patient was twenty-five years old, primipara, with scolio-rachitic flat pelvis the measurements being: A. S. S. 27.5 cm.—Cr. II. 28.5 cm.—Tr. 33.5 cm.—

D. B. [ext. conj.] 17.5 cm.—C. D. 8.75 cm.—C. V. 6.75 cm. She was told to return when seven months pregnant in order that the question of induction of labor could be determined, as against permitting her to go to term to be delivered by Cæsarean section. She did not return until the thirty-sixth week of pregnancy, when the child was too large to permit of its delivery alive. Symphysiotomy was considered but rejected on the ground that the pelvic deformity was extreme for the operation. The patient was prepared for operation by the use of baths, by having the bowels kept open, and by daily exercise out of doors. The operation was done on the 28th of September when the patient was estimated to be in the 40th week of gestation. When etherization was complete five grains of ergotine and one-fortieth of a grain of sulphate of strychnia were given hypodermically and an additional five grains of ergotine were given towards the close of the operation. The usual antiseptic precautions were followed. A free six-inch incision was made and the uterus incised *in situ*; hæmorrhage was free but not alarming and was kept out of the peritoneal cavity by pressing the abdominal walls against the uterus. The uterine incision extended well up toward the fundus, purposely avoiding the lower segment. The baby, a girl, was delivered by the feet and was soon crying lustily. As the baby was delivered, the uterus was withdrawn from the peritoneal cavity and the cervix was compressed manually. Contraction was good and the hæmorrhage at no time annoying. The placenta and membranes were carefully delivered and two fingers passed down through the cervix to secure a patulous canal for the lochia. Seven deep sutures [avoiding the mucosa] were now passed and tied; and fourteen superficial stitches. The uterus was now rinsed off with boiled water, the wound dusted with aristol and the usual dressing applied. The after-history was uneventful.

DR. MORDECAI PRICE reported a CASE  
OF APPENDICITIS.

The patient had suffered a number of years with what was supposed to be liver trouble; there was tenderness over the right side of the body, but no examination was made as there was no suspicion of any trouble up to eighteen months of her

death. Then her physician noticed a large symmetrical tumor filling up the entire lower abdomen. Operation was refused for the reason that, in her greatly emaciated condition and the feeble character of her heart, no encouraging prognosis could be given. The tumor ruptured and discharged through the bowel, after which the patient greatly improved. She had a number of such attacks extending over the eighteen months, when the tumor again filled up and ruptured, but she was not able to rally from the septic condition brought about by the suppuration.

The post-mortem showed a large abscess at the end of the appendix. The abscess was adherent to all the viscera and extended from crest of ilium to crest of ilium.

#### DISCUSSION.

DR. JOSEPH PRICE said that, in dealing with troubles in the appendix, promptitude is of paramount importance. He scarcely attended a medical meeting without being told of dozens of deaths from appendicitis.

In regard to Dr. Davis's case, he would suggest that the patient is in precisely the same condition that she was when he operated and the indications are precisely what they were at first. He would dread to allow that woman to go over night, if she were his patient.

DR. G. BETTON MASSEY said that Dr. Price's case was particularly interesting in connection with that of Dr. Davis. In the one case, grave and serious, the waiting policy has been adopted; in the other it seemed to him that the operation had been too hasty. Dr. Davis's case is reported as a hæmatocele but he thought it had better be called a hæmatoma. He had no doubt that the abdomen was protected from invasion, as Dr. Davis had to separate adhesions to reach the blood. He had had two or three cases which disappeared under expectant treatment and forced absorptive methods with the negative galvanic pole in the vagina.

DR. M. PRICE said that if Dr. Massey had ever seen a case of extra-uterine pregnancy he should think it would have taught him a lesson in regard to waiting. Dr. Price had seen ninety-seven extra-uterine pregnancies operated upon and had never yet, in twenty-three years experience, seen a true hæmatocele. Therefore, he concluded that true hæmatocele must be rare. He thought such a condi-

tion did exist but concluded that Dr. Davis's case was one of extra-uterine pregnancy and that the condition would turn out to be the same on the other side also.

#### DR. CHARLES P. NOBLE reported a CASE OF TRUE PELVIC ABSCESS.

Mrs. H., aged 28, was delivered of her second child by a midwife, the labor being followed by septicæmia. Five weeks later she came under the notice of the writer. On examination the right broad ligament was found indurated and a mass of exudate extended on the right side of the abdomen almost as high as the umbilicus. At the operation the viscera in the lower right quarter of the pelvis were found fused together. The patient took ether badly and it was thought that an attempt to free the adhesions would result in a death on the table from ether. An unsuccessful attempt was therefore made to reach the pus by an incision near the anterior superior spine of the ilium. The patient improved for a few days, when a second attempt was made under chloroform, which however produced as much cyanosis as the ether had done. An incision was made directly over the broad ligament, evacuating several ounces of pus. With rubber drainage a satisfactory convalescence followed.

Twenty months later an operation was done for the cure of a ventral hernia which had formed at the site of the third incision. The operator was surprised to find that the adhesions had all disappeared except a point of adhesion between the omentum and hernial sac and another between the omentum and broad ligament. Both appendages were healthy, which demonstrates that it was not a pyosalpinx but an abscess of the broad ligament.

The disappearance of the very extensive adhesions in this case is worthy of record as showing that peritoneal adhesions are not necessarily permanent. Undoubtedly acute pelvic cellulitis and true pelvic abscess do rarely occur as puerperal conditions, but they are extremely infrequent as compared with pelvic peritonitis, pyosalpinx, and purulent peritonitis.

#### DISCUSSION.

DR. M. PRICE thought that leakage could take place from a tube and an abscess result which is not in the tube but walled up by the peritoneal inflammation,

making it extra-peritoneal. He was confident that a number of these abscesses, said to be of the broad ligament, are abscesses following some injury in the abdominal wall near Poupart's ligament, or between the peritoneum and the muscular structures of the abdomen, posterior to the peritoneum.

DR. GEORGE E. SHOEMAKER said that abscess of the kidney sometimes occurred in this region as in the case of his own. Adhesions may be of a most serious character and invalid the patient. A short time ago he had operated on a patient who had been previously operated on by a member of this society, presumably in the best manner, but she had been for a year following the section a complete invalid. Dr. Shoemaker found a firm adhesion to the right broad ligament the size of a quarter. This had to be cut off and the bowel stitched. He did not believe that such an adhesion would be absorbed. After this adhesion was released she was well for the first time since the previous operation.

DR. JOSEPH PRICE said that we all know that pus in the pelvis follows traumatism and particularly puerperal traumatism or filth, or that it follows some of those stab-wounds in criminal abortion. In regard to the absorption of the adhesions—why does it not take place in the healthy adhesions following a great number of sections in which we have to repeat the operation for ventral hernia? Adhesions once formed are exceptionally absorbed or released; and in this case, with fixed omentum and fixed bowel, he doubted very much if there were not some error in the first section.

DR. GEORGE M. BOYD said that it seemed to him that we had inflammatory pockets and localized extra-peritoneal inflammation more often than is generally supposed, as the result of extensive cervical lacerations and the various tears of the vagina. This case seemed to be one of vaginal origin.

DR. C. P. NOBLE agreed with Dr. Price that true broad-ligament abscess is rare, but it sometimes occurs. Dr. Joseph Price says that we do have suppuration in connective tissue in puerperal cases, particularly after criminal abortion. Of course this point has always been made. We have taken the position that in the great majority of cases the pus is in the tubes or within the peritoneum, but Dr. Noble thought that in the first enthusiasm

of finding out that most cases of pelvic inflammation were not cases of pelvic cellulitis or true pelvic abscess, some took the exaggerated position of denying that we ever have cellulitis or pelvic abscess, and went a little too far; and for the sake of exact truth we must admit the existence of this condition. Why some adhesions were absorbed and others not, he did not know. It was impossible that he should have made a mistake in this case as he had his fingers on the adhesions.

DR. G. BETTON MASSEY reported a CASE ILLUSTRATING THE TREATMENT OF PAINFUL PROLAPSED OVARIES IN YOUNG GIRLS.

The patient is a young lady of a sensitive, literary family, with an introspective bent. She menstruated early and, like many young girls, had painful periods. She was ill-developed physically and the periods were also irregular. The surgeon who was consulted is said to have diagnosed endometritis and uterine prolapse to a moderate degree, and a pessary was inserted. After the pessary had been worn for a little time it was removed, but not before it had caused great aggravation of the pre-existent condition. The case went from bad to worse, there were numerous consultations with physicians and surgeons, and removal of the ovaries and tubes was advised by several.

When seen by the writer, three years later, she was twenty-one years old. The uterus was in a condition of catarrhal inflammation, enlarged and tender; the ovaries, particularly the left, were prolapsed and very tender, although not enlarged. The position and painful condition of the ovary was, the writer thought, the condition which led so many surgeons to advise the unsexing of this young lady.

She was placed on rest, electrical treatment for her neurasthenia, and subjected to vaginal treatment by the galvanic current with a covered positive electrode. This resulted in a great amelioration of the tenderness of the left ovary. Up to this time the uterus had not been explored but, owing to the copious catarrhal discharge, a flexible aseptic sound was passed and the uterus found to be over three inches in depth, showing a greater source of trouble than the ovarian displacement. She was then put on the direct treatment for the endometrial inflammation with intra-uterine galvanic and faradic currents.

This was followed by marked improvement and recent advices state that she is entirely well, natural in her periods, and gaining flesh. The ovary still remains rather lower than the other but freely floating, and the writer thought that the slight deviation of position of that ovary would not cause any more trouble than a like freedom of movement of any of the other internal organs.

#### DISCUSSION.

DR. GEORGE E. SHOEMAKER doubted if the patient's statements in the case of this kind should be accepted, and doubted very much if a girl giving such a history would go to several eminent physicians in this city and be told by nearly all that the ovary should be removed and yet be capable of cure by such slight treatment. He would remind Dr. Massey that increased length of the uterus need not go unsuspected until the sound be introduced. Bimanual examination will detect it more readily.

DR. CHARLES P. NOBLE said he had never had a sick woman consult him who had been advised to have the ovaries removed and found nothing the matter. He thought that those who cast such imputations upon surgery should put themselves in a position to demonstrate that such things are true, and not take the statements at third or fourth hand.

DR. JOSEPH PRICE said he often had patients, coming from a recognized operator, state that the doctor had recommended the removal of the ovaries; it was only necessary to ask a few questions to be able to tell the patient that probably the doctor was right; and in ninety-nine cases out of one hundred the examination showed that the physician was right. Dr. Massey makes a good point in regard to pessaries. Gynecologists know that it is important to correct displacements before using the pessary. The pessary is not to correct the displacement but to prevent its recurrence.

DR. MASSEY stated that the surgeons were New York men. His authority was her physician, the patient herself and her sister. In justice to her previous attendants he would say that the case had been treated by conservative, non-electrical, methods before coming into his hands,

ELLISTON J. MORRIS, M. D.

*Secretary.*

#### PHILADELPHIA COUNTY MEDICAL SOCIETY.

*Meeting of November 23, 1892.*

DR. WHARTON read a paper on "Treatment of Ischio-Rectal Abscess and Fistulo-in-Ano." (See page 965)

#### DISCUSSION.

DR. THOMAS S. K. MORTON: I am glad that Dr. Wharton has insisted upon early operation in ischio-rectal abscess. This affection involves loose cellular tissue richly supplied with lymphatics, and may give rise to profound septicæmia, if not pyæmia, if not relieved early. I have recently heard of a case of small ischio-rectal abscess which gave rise to pyæmia and death. The incision should be made as soon as the brawny induration is evident, feeling certain that if there is any inflammation in this region, where the tissues are so poorly supplied with bloodvessels and other means of destroying septic material, suppuration will follow.

In washing out these abscesses with a strong antiseptic solution it is important to see that all that goes in, comes out, and that none enters the bowel, for a few drachms of a strong mercurial solution entering the bowel would give rise to poisoning.

The packing should be applied loosely. Here, as well as elsewhere, much damage can be done by too tight packing. There is something about iodoform gauze that makes it superior to every other material for packing. What this is I do not know, but under its use the dressing is drier, there is less pus, and the whole case goes on in a more orderly and rapid manner. I like also to rub iodoform into the walls of these abscesses and into the sides of a fistula. Peroxide of hydrogen is one of the best antiseptics in these cases.

In regard to the bowels, I have a predilection for keeping them loose in all operations about the rectum, and very early give such drugs as will produce partially liquid stools. This gets rid of the great pain and the terrible anxiety of the patient looking forward to the movement of bowels that have been constipated for several days after an operation.

Repacking is important, but in many cases simple inspection, particularly in fistula, is all that is necessary to see that

healing is progressing properly, and, if necessary, the wound can be painted with some stimulating solution, as a fifteen-grain solution of silver nitrate, balsam of Peru, etc. By careful watching, the painful process of repacking can often be avoided, although in some cases it will be required to secure uniform healing from the bottom.

Coming to fistulo-in-ano, we should bear in mind that there are two great varieties: one is the tubercular, and the other simple or traumatic, where a small foreign body perforates the wall of the rectum and sets up inflammation in the cellular tissue. Probably the ones that form slowly are simple, but may become infected with the tubercle bacillus. Granting that the large majority are tubercular, the treatment must be thorough and radical in order to get rid of the tubercle bacillus.

I agree with Dr. Wharton in regard to the use of the ligature, that only cases involving high section of the bowel justify that method. By this method we are apt to overlook the branches which are so common.

It is not always best to carry the director through the fistula and lay it open at once. It is sometimes better to dissect from the outer opening, treating the branches as they are met with, rather than to make the incision and have the field of operation obscured by blood.

The excision of the fistula has not proven a success. I have conversed with one or two men who had much to do with the introduction of this method, and they acknowledge that after using it for several years it has proved far less useful than had been hoped. There were but few cases in which excision could be done, and of these few, the majority suppurated, and the edges of the wound had to be separated.

In fistulas that are tubercular, and perhaps, in all, after thorough dissection and opening up all branches, I have wiped the wound out with pure caustic potash. That stops the hemorrhage, it kills the lining membrane throughout, and perhaps some healthy tissue, but I think that we get a more radical operation, particularly in tubercular cases. We must, however be careful not to go too deep. After using the caustic potash it is well to carry over the wound a sponge saturated with vinegar, in order to stop the action of the alkali.

The induration tissue can also be destroyed with the Paquelin cauter, but when this is used the surrounding tissues must be very carefully protected from the radiating heat.

There are scarcely any fistulas that cannot be benefited by operation. There are many that cannot be cured, but all that I have seen have been benefited. I can recall several cases that are going about with a small sinus running high up, but yet are remarkably comfortable when contrasted with their former deplorable condition.

DR. A. J. DOWNES: Neither of the gentlemen has referred to multiple fistulas. I recently had such a case in a tubercular woman forty-two years old. During the past ten years she had had four ischio-rectal abscesses that had opened, and numerous other phlegmons that had not opened. I operated on her four weeks ago at St. Joseph's Hospital. I found four fistulas. On the left, two, one close to the external sphincter, and entering the bowel behind the internal sphincter; the second, an inch and a quarter from the margin of the bowel and entering the bowel an inch and a half from the anal margin. On the right side there were two, whose external orifices were two inches apart, and an inch and a half from the margin of the bowel. In operating I cut through the left side at right angles to the sphincter, and on the other side made a wedge-shaped incision, extending above the opening in the bowel, including both fistulas. I expected to cut the sphincter, on this side at a subsequent operation. Sixteen days later I etherized and found that I had succeeded in closing the internal openings on the right side. I had thus succeeded in one operation in curing the four fistulas with but one incision through the sphincter, nor can I see why it should be necessary to even cut the sphincter twice in any case.

On two occasions in the office, I have used the rubber ligature for fistula in otherwise healthy people, with excellent results.

DR. J. M. BALDY: I have been somewhat surprised at the small amount of space that Dr. Wharton has given to excision of fistulas and to the utter condemnation of that treatment by Dr. Morton. My experience has been so contrary to this that it may be of interest to mention it.

In past times I have treated fistulas by cutting and packing, and I have seen a number of cases in which non-control of the sphincter continued for a long time. I then gave excision a trial, and I have never in a single instance regretted its use. Nor have I had a single failure in the ten to fifteen cases in which I have employed it in the last two years. In simple fistulas I have slit open the fistula, and with curette, scissors, or thin-bladed knife removed the indurated tissue, and then have placed sutures buried completely around the fistula; and have finally closed the mucous membrane, from the bowel, with catgut sutures. Where there have been multiple sinuses I have cut out all partitions between the sinuses. In one case the opening was one-half to three-quarters of an inch in width. I rubbed in a strong antiseptic solution, obtained primary union, and a perfect result. I remember a case in Trenton on whom a perineal operation had been done by a friend. This was followed by an ischio-rectal abscess with an opening into the rectum. The lady was also suffering from hemorrhoids. I laid the fistula open, exposing a cavity that looked most formidable. The slit in the bowel was probably two inches long. I curetted the cavity, rubbed in a strong bichloride solution, taking one-half to three-quarters of an hour, closed the wound with sutures, which did not go within an inch of the bottom, whipped the bowel together with catgut, and closed it without drainage, at the same time removing four hemorrhoids. Ten days later I removed the sutures, and in another ten days the patient was up and about, and the opening closed.

As I have said, in none of these cases operated on have I had cause to regret excision, and I should prefer it to all other methods where it was possible to introduce sutures, and nearly, if not fully, bury them all the way round.

In all my bowel operations I keep the bowels open from the first, and after the first passage the patients do not have much trouble. They are more comfortable than if they are permitted to have semi-hard discharges passing over tender surfaces.

DR. WHARTON: I am glad that Dr. Morton has called attention to the importance of using the bichloride solution so that none of it is retained in the rectum.

I cannot say why it is that iodoform gauze is so exceptionally good a dressing in these cases, but it is certain that it does better than any other material. I also use the powdered iodoform.

Practically the second dressing is not a repacking. I simply pass a piece of gauze to the bottom of the wound and allow it to project between the edges. I have also used the method referred to by Dr. Morton without repacking.

I use the caustic potash in many cases, particularly where the walls of the sinus are very dense, but neglected to mention it in the paper.

In the chronic cases that have been operated on many times, I think that the great secret of treatment is thorough cur-etting and free drainage. If the sinus can close so that pus can accumulate, the patient suffers. If the drainage is free the patient is more comfortable.

In regard to double fistula, I spoke of this under the head of horseshoe fistula, and recommended one division of the sphincter at a time.

Dr. Baldy's results has been very satisfactory. I have myself not had a very extensive experience with excision. I meet with many cases in which the operation could not be satisfactorily accomplished, and in these I prefer incision.

If the bowels are moved promptly after the operation it is apt to disarrange the packing, and sometimes the first packing is important in controlling hæmorrhage from the wound.

#### MILWAUKEE MEDICAL SOCIETY.

*Meeting of November 8th, 1892.*

DR. LEWIS G. NOLTE, Milwaukee, presented a "Report of Two cases of Nephrectomy—Recovery."—(See page 956).

#### DISCUSSION.

DR. A. H. LEVINGS: This paper of Dr. Nolte's I have been very much interested in. There are some points in it that might be well discussed, I think. In regard to the use of the aspirating needle, I believe in the majority of cases a diagnosis can be made without it; that is we can easily make a diagnosis of pus in the urine; but I believe also in the majority of cases, in fact nearly all, with the microscope if the

pus comes from the kidney you find the peculiar characteristic cell formation. Also if the abscess has extended into the kidney that you may get the cells of the different tubes. If the pus comes from the bladder wholly you will get the characteristic bladder epithelial cells. The rule is, so far as I know, in the microscopical examination of these cases, that if the pus comes from the bladder or from the kidney the cells characteristic of the source will predominate. Of course you always have more or less cystitis in cases of suppurated kidney, but if the pus comes from the kidney, and you are so to diagnose it, the cells must predominate over those of the bladder.

Whether to remove the kidney in the primary operation or not is a question. I think the majority of operators, Shape for instance, are very strong on this point—that unless you are sure that the abscess is tubercular the kidney should not be removed, but simply incised; see if you cannot save it and if the abscess will not heal. The majority of these cases are undoubtedly tubercular. I believe that is the case. And a tubercular kidney if it can be removed had better be removed.

In the removal of the eleventh or twelfth rib or both, as a rule, I think, that it is not intended in these cases to extend the incision up to the point of the ribs but the object is simply to get more space for retracting the wound. It is well known that the pleura extends half an inch below the twelfth rib, but by resecting the twelfth rib, you can open the wound further.

DR. NOLTE: I would say that finding out where the pus comes from does not tell us at all the vital point. It does not tell us which kidney is involved, and that is the most important point and that is where the aspirator should be employed. Why not operate on tubercular kidneys? I think the rule is as set down by S. W. Gross that you should operate in primary tuberculosis. I find from the literature that pyonephrosis is the rule and primary tuberculosis is the exception, contrary to the view apparently taken by Dr. Levings.

Again as to the point of the pleura extending below the twelfth rib, that is only once in a while the case. The rule is it does not extend further than between the eleventh and twelfth ribs.

DR. H. M. BROWN: I am quite as-

tonished to hear Dr. Levings express himself as he has in the matter of the use of the aspirator. I do not see any good reason why you should not use the aspirator. It does not do a particle of harm—it cannot do any harm—and it gives you a certain means of diagnosis providing you have no better means at hand, I mean the method of seeing the character of urine coming from the different kidneys—and even then why should you not use the aspirator. One of the most prominent surgeons of the United States, Dr. Senn, was remarkably fond of using the aspirator and more than half of his diagnoses in regard to the extent or character of tumors was made with the aid of the aspirator needle, and I think if he were to tell the truth, as I am inclined to think he does as near as any of us do, that has helped him more than anything else. In the cystoscope a man has at hand a method of making an absolute and extremely early diagnosis as to which kidney is affected and how much. After once or twice using it, the urine can be seen trickling from the ureters into the bladder and can be seen uniting, when pus is coming from one kidney and clear urine from the other, with as sharp a line of demarkation as exists between the muddy waters of the Missouri and the clear waters of the Mississippi; and such means for diagnosing which kidney is afflicted, is certainly a most valuable one. It is a far prettier picture than the one I have spoken of, and I think it would be a very good plan for the gentlemen who have cases under their charge in which they suspect abscess or cystic pyosis, or degeneration of either kidney, to employ the means suggested for diagnosis. They may borrow my instrument and try it:

I was also astonished to find that Dr. Levings, unless I misunderstood him, thought it was not a good plan to operate on a tuberculous kidney. I do not know why we should not operate as quickly on that as on any tubercular cavity. Tubercular material is essentially a foreign body, and I see no reason why we should not operate at once on tuberculous kidney tissue, early if we can, late if necessary. Because a man has a few nodules in his lungs you should not hesitate to remove tuberculosis of the elbow or knee-joint. Why not remove the affected part as early as possible? And I think the consensus

of opinion, as far as my experience goes, is in favor of early and late operation upon tubercular diseases of the kidney.

Again, Dr. Nolte is more than right when he claims that the majority of cases of pus destruction of the kidney are not tuberculous. There is not one of us here who has not had in his post-mortem experience almost numberless instances where one kidney was almost entirely destroyed from the presence of stone and cystic degeneration of the kidney, which at some time had been an acute inflammatory trouble accompanied by pus and all the symptoms of pus infection, chills, fever, etc., and which if the kidney had been operated on and nephrotomy had been made, the kidney itself, or at least a greater part of it, might have been saved for further use; the cause of the trouble and some of the kidney would have been removed and a useful kidney would have been spared to the patient. In conclusion it seems to me that such grounds as Dr. Levings has taken in regard to the treatment of a majority of these cases should be avoided.

DR. LEVINGS: Dr. Brown has entirely misquoted me. What I said is that a tubercular kidney should not be drained, it should be removed—if I did not, that is what I intended to say.

DR. NOLTE: I would say in conclusion that my cases were both so far advanced that neither the cystoscope nor any other means of determining from which kidney the trouble proceeded, was necessary. I had a tumor in each case and had no hesitancy in using the aspirator needle.

One of the most beautiful methods I ever saw employed was by Sabine in New York, in a case of Dr. Weir's. He introduced his hand into the rectum up to the sigmoid flexure and compressed the ureter. He could very easily compress either one of the two ureters at will, and in the mean time the urine which had secreted in the bladder was collected from the other kidney which secretes at the rate of a few drops every few minutes and a diagnosis was made out very easily. This was a case in which there was no tumor whatever and in which Dr. Weir subsequently operated and brought forth a kidney that was riddled with abscesses.

DR. A. J. BURGESS: I think Simon, of Heidelberg, was the man who first employed the method of introducing the

hand into the rectum for the purpose of diagnosing kidney trouble; but it was found after he had used it awhile that the rectum was in such a dilapidated condition that it was not considered a very practicable method. A few rents with a few cases of death from peritonitis were the result.

In regard to the diagnosing of kidney troubles where there is a great deal of cystitis, by the use of the microscope, I must confess I have been pretty cloudy on the subject. I have a case now under torture, where I have examined the urine a good many times. I have found cells which one would ordinarily suppose came from the kidneys, but this case has been one of cystitis of three years' standing, and of course there has been a great deal of inflammatory trouble in the bladder, and the small cells from the new layers of epithelium in the bladder oftentimes are so like those in the kidneys that it certainly takes an expert to know the difference; and then supposing you have the trouble arising from a stone which has become impacted in the ureters—what good are you going to do with your microscope? You may perhaps have trouble with the bladder also; the ureters may be stopped up and no urine or but very little coming down and that intermittently; you are at sea again. You may think you have cells which come from the kidney which really did not because they could not.

In regard to the use of the cystoscope, if we were going to borrow Dr. Brown's, I should want to borrow Dr. Brown also. The statements I have heard in regard to the cystoscope are entirely at variance with Dr. Brown's statement; and Finger, of Vienna, says it is much harder to learn to use than is the ophthalmoscope and much more uncertain in its results. Dr. Dietel, seventy-four years of age, and a specialist on genito-urinary diseases, used the cystoscope at first for a good while, but practically only to make demonstration of its use rather than to make diagnoses with it. He thinks that the ordinary symptoms and the experience he has had, will lead him to more correct diagnosis ordinarily than will the systematic use of the cystoscope. That instrument was used considerably two years ago, and I remember one man who was quite an enthusiast who had discovered an instance of stone by the use of the cystoscope and another instance of

tumor; but on opening the bladder to remove them there was nothing found.

The method of catheterizing the ureters also has been used to some extent; and in that connection I remember to have seen Eberson, of Copenhagen, trying to catheterize the ureter in a woman and he worked at it an hour and finally got the catheter into the uterus but no urine ran out. He drew it out and found it was plugged with a clot. He "monkeyed" around for an hour and got it in again but it plugged right up again with another clot. And, after an hour and a-half the ureter had to be incised to admit his finger. Of course in the male the operation is still more difficult.

In regard to the removal of tuberculous kidneys, it would be a very good thing to do always, of course, if you could be absolutely certain there was no such trouble in the other kidney. There apparently is no reason theoretically why one kidney should be infected much sooner than the other. Of course it does so happen often, but oftentimes the affection is coincident, and there is no way of being absolutely certain in regard to it. So some operators have been in the habit of doing first a nephrotomy to see if that would perhaps relieve the patient, and, if not, and the other kidney was found to be in good condition, later, through watching its functional activity, a secondary nephrectomy could be made. Practically it is difficult to do that on account of the large amount of scar tissue that is apt to form.

In regard to the resection of the ribs, I have seen that done once only and it seemed to me that there was no space whatever gained by the resection; at least it brought the operator to no result and did not seem to give any more room in the place where room was wanted than he had before.

for catheterism in the female is previous to and during the first stage of labor, especially in *primiparae*. During a long, varied and quite extensive practice as a country obstetrician I invariably examine the suprapubic region in order to ascertain whether or not the bladder is full. I claim that it is not at all uncommon to find the viscus distended with urine, which in my opinion is caused by partial paralysis of the constrictor muscles at the neck of bladder superinduced by pressure of the gravid uterus, and in *primiparae*, a general compactness of the pelvic ligaments, bones and tissues. I agree with commentator in the article above referred to that "the straight tube is preferable to the curved one in women." It is easier of introduction, more thoroughly aseptic, and foreign matters are more easily eliminated through it. Another advantage is that it can, if not too long, be introduced in *almost* any position of the patient. I have never used a glass catheter, but can see no particular advantage in them. The one I have found most convenient is Tiemanns' soft rubber catheter stiffened *for introduction*, with a wire. I always use a No. 10 or No. 12. I often use a gum elastic catheter which is always destroyed when no longer needed. The same catheter is never used in two subjects. Another point is that after using them I always clean my catheters by placing them with other instruments in a hot solution of carbolic acid, forty per cent. and allow them to remain in it for about a half an hour. I have never, in these cases, used the double current catheter. At some future time I shall have more to say on the subject of catheterism in the male.

Respectfully yours,

A. O. STIMPSON, M. D., C. M.  
Thompson, Pa. Dec. 7th, 1892.

## Correspondence.

### CATHETERISM IN THE FEMALE.

Editor of THE MEDICAL AND SURGICAL REPORTER:—My attention has been called to this subject by remarks made on the style of catheters to be used in the female subject, on page 908 of MEDICAL AND SURGICAL REPORTER, of December 3d, '92. The most frequent use I have found

### CATGUT AS SUTURES.

Editor of MEDICAL AND SURGICAL REPORTER:—In your issue of Nov. 12, there appears an abstract of a paper originally published by Klemm, in the *Bulletin Generale de Therapeutique*, in which strong condemnation is made of the use of catgut in surgical practice. From an extensive experience, both experimental and clinical, I am sure the deductions of Klemm are absolutely false and therefore misleading. Soon after the publication of

the paper in question Dr. J. F. Binnie Professor of Surgical Pathology in the Kansas City Medical College, and myself undertook some experimental work to determine the comparative value of catgut, silk, silver wire, silk-worm gut and kangaroo tendon—particularly as regards the setting up of suppurative or other infectious processes in wounds. The results conclusively prove the inaccuracy of Klemm's observations, provided sterile gut is used under perfect aseptic conditions.

As to the statement of Klemm that "when catgut is employed in surgery suppuration occurs in spite of all precautions," I knew from long experience that it was not true, but decided to make a careful series of observations, assisted by Dr. T. B. Thrush, House Surgeon at All Saints Hospital, Kansas City. So during the past few months close watch has been kept on 8 cases of trephining for idiocy, epilepsy, tumors of brain, etc.; 9 laparotomies for pyosalpinx, ovarian tumor, etc.; 4 abdominal hysterectomies; 2 gastrotomies; 4 recent perineorrhaphies; 1 removal of the Gasserian ganglion; 2 excisions of the ankle; 4 amputations; 1 Wyeth's amputation at hip; 2 club-foot operation in which excision of bone was made; 3 excisions of cancers; 3 herniotomies; 2 varicoceles; 1 trephining the spine; and 2 castrations. In cases of cystotomy, prostatotomy, excisions of ribs, amputations for injury, operations on the rectum, the perineum, etc., no attempt was made to use catgut since the field of operation could not be rendered aseptic. In the 48 cases here mentioned more or less pus formed in three cases: (1) a case of tuberculous empyema of the ankle; (2) in an amputation where carbolized gut had to be used instead of juniper-oil gut; (3) in the laminectomy for extra-dural tumor producing paraplegia, when the incision was through a large bed-sore not properly cleaned. The remaining 45 cases completely annihilate the anti-catgut men—there is no way of escape.

Any surgeon who will take the pains to clean his field of operation by carefully scrubbing with soap and brush, drying, washing with sulphuric ether, applying a saturated solution of permanganate of potassium until the parts are stained a deep mahogany color, decolorizing with a strong solution of oxalic acid and finally douching with solution of bichloride of

mercury, will have a surface upon which he may use as much catgut as necessary without the slightest fear of suppuration, providing the hands are thoroughly disinfected by the same process, all instruments boiled for 20 minutes in a 5 per cent solution of carbonate of sodium just before using, and a good catgut be employed. Carbolized catgut is unreliable, even dangerous: juniper-oil gut, properly prepared, is absolutely safe.

Very truly yours,

EMORY LANPHEAR,

Kansas City, Mo. Dec. 6, 1892.

#### STERILITY IN THE MALE.

Dr. L. Seeligmann states that matrimonial sterility caused by the husband may be due to the following causes:

1. Impotentia coeundi.
2. Aspermatism.
3. Azoospermia.

Of these three causes of male impotency, the comparatively rare condition of impotentia coeundi, and the almost equally rare condition of aspermatism, we may pass by and proceed to a consideration of azoospermia as the most frequent cause of sterility, or rather impotency, in the male.

Azoospermia, or a change in the ejaculatory fluid in which both quantitatively and qualitatively the semen is apparently normal, but in which the most important element, the spermatozoa are absent, can be caused by the following:

1. Stoppage of the vasa deferentia in consequence of inflammation or traumatism.

2. Nutritive disturbances of both testicles:

- a. Occurring after funiculitis, epididymitis, and duplex orchitis.

- b. From constitutional diseases; syphilis, tuberculosis, chronic alcoholism, diabetes mellitus, etc.

- c. From varicocele, hydrocele, kryptorchismus.

3. Atrophy of the testicles:

- a. After sexual excesses.

- b. After long indulgence in onanism.

- c. After injury to certain parts of the brain, especially of the cerebellum.—*Weekly Med. Review.*

THE  
**Medical and Surgical Reporter**

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ISSUED EVERY SATURDAY

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THE MEDICAL AND SURGICAL REPORTER.

SATURDAY, DECEMBER, 17TH, 1892.

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SOME SIGNS OF THE TIMES.

"If the profession is to rise in the estimation of the public, the portals must be narrowed, and the evidences of the capability for entering a highly honorable and terribly responsible profession must be made more and more stringent. The neophyte must not only know, he must be able to put his knowledge into practice before he is let loose to command the issues of life or death. And I hold there is no plan surer to bring about this condition of things than to set the learner to try to do the work for himself, as is the almost invariable rule in every line of life, under proper and responsible supervision."

This is the conclusion of a strong letter from Dr. Bruce, Direct Representative for Scotland on the General Medical Council,

to the *British Medical Journal* (Nov. 26 '92). He is urging the necessity of higher education in the medical profession of Great Britain. In that country, with its profession jealously supervised by a General Medical Council of great powers, with that insular tendency to introspection yecept conservatism, with its ancient and honorable institutions of learning, no sooner has the five years' curriculum been established than the cry is made to raise yet higher the standard of the profession.

In painful contrast to this an editorial in *Daniel's Texas Medical Journal* (Nov. '92) affords an illustration of a standard of medical education that will meet legal requirements in some parts of this country. Unfortunately the illustration could apply to the majority of the States and Territories of the Union,—even to Pennsylvania. Speaking of the mortifying lack of success of the Texas Medical College, the editor says:

A magnificent building was constructed, and every department thoroughly equipped for teaching modern medicine. An able faculty was secured, and a high and thorough curriculum was arranged, extending over three years' graded courses. No longer should it be a reproach to Texas that with her princely school fund and her university, where all else is taught, her sons were compelled to go abroad for medical education. After ever so many obstacles overcome, at last the doors of a magnificently prepared medical college were thrown open and students were invited to come in. They didn't come. \* \* \*

Let it be understood that in this State a diploma is a diploma. There is no discrimination observed whatever, and practically one diploma is as good as another. A man who can go into almost any Southern city, and after three months attendance on lectures, return to Texas and begin practice; or who can go, it may be, without intermission, from a three months' course at a winter school (which has cost him, say \$50 for tuition), right into a summer school, where after three months more and another \$50 fee, he can secure a diploma which will entitle him to recognition by the profession and all the rights and privileges of a legal practitioner of medicine in Texas, can hardly be expected, in these days, to sacrifice so much to patriotism as to attend three years at a home school and pay \$140 each year unless, thereby, he could secure a diploma which would give him certain advantages over the cheaper sort; in brief, Texas cannot expect to keep her students at home so long as a diploma from a two

year school and \$50 fees is put upon the same footing before the law. \* \* \*

Every effort to secure legislation which will require something more than the mere possession of a diploma (from any source) as a requisite to the privilege of practicing medicine in Texas, has been laughed to scorn. And now, the senators who mocked those efforts are confronted with a problem hard to solve, and they must take their choice between keeping up a costly establishment and paying a teaching corps high salaries to lecture to empty benches—or they must offer Texas students other inducements, or protection from competition with cheaply made doctors. The first thing to be done, in our opinion, is to reduce the cost of lectures to the matriculation fee and anatomical fee only. If then our five hundred students still refuse to be highly and thoroughly educated, pass a law which will admit to practice in Texas no man whose diploma has been issued by a school requiring less than is required at Galveston.

However, the situation is not so hopeless as if relief were entirely dependent on the Legislature. Experience has constantly shown that, in the onerous duties of saving the country, the law-makers can spare but little time in considering matters in which they can discover no prospects of immediate beneficial returns. Only by patient and persistent effort can they be educated to an appreciation of the importance of allowing none but men of the highest grade of ability and education to deal with issues of life or death among their families and friends.

Six months' attendance on lectures (!) and \$100 will obtain a diploma in "almost any Southern city,"—a condition of affairs not confined to Southern cities. A bitter caricature of American Medical Science.

Southern practitioners are fully alive to the situation. In some States, notably Virginia, they have secured legislation which will go far to extirpate the reproach of "diploma mills." But impatient of the tedious process of law-making they have devised a method which will greatly hasten the growth of public opinion necessary to compel the desired legislative action, meanwhile working mightily to advance medical education.

In a private letter, Dr. Luther B. Grandy, editor of the *Atlanta Medical and Surgical Journal*, who has been actively

identified in the movement, says "Some of us down here have been engaged in proclaiming the gospel of a higher education, and recent events encourage us to hope that our labors will not be in vain. The Southern Medical College Association was inaugurated the other day and many of the evils which have existed heretofore in our educational system we are persuaded may now be corrected. We propose to keep up the fight until the desired results are obtained, or at least until better conditions prevail than at present. The improvement in our system of medical education down here, the lengthening of our terms, the increased requirements both for matriculation and graduation, is a consummation devoutly to be wished. This will give us better schools and better doctors." These are the sentiments of all of the progressive men in the South, and the influence that will be exerted by the association will rapidly make itself felt throughout the entire section. We give below a schedule of the organization of the Southern Medical College Association.

#### RULES AND REGULATIONS

##### FOR THE ORGANIZATION AND MAINTENANCE OF THE SOUTHERN MEDICAL COLLEGE ASSOCIATION.

This Association shall be composed of delegates from Southern Medical Colleges, whose Faculties have signified a desire to become members thereof, signed these rules of organization, and paid the membership fee of \$5.00.

The objects of the Association are to cultivate closer and more intimate relation between medical colleges and to elevate the standard of Medical Education by requiring a more thorough preliminary training and an increased length of medical study.

The Association shall be composed of one or more delegates from each Medical College, belonging thereto, who shall be elected annually by their respective faculties. Each college shall be entitled to one vote in the transactions of the Association.

The officers shall consist of a President, Vice-President, Secretary and Treasurer, who shall be elected annually, just before the adjournment of the annual meetings, and shall perform the respective duties, pertaining to these offices in similar organizations.

The meetings of the Association shall be held at the same time and place of the meetings of the Southern Surgical and Gynecological Association, unless otherwise determined by the Association.

#### REQUIREMENTS FOR MATRICULATION.

Every student applying for matriculation must possess the following qualifications:

He must hold a certificate as the pupil of some known reputable physician, showing his moral character, and general fitness to enter upon the study of medicine.

He must possess a diploma of graduation from some literary or scientific institution of learning, or certificate from some legally constituted High School, general Superintendent of State Education, or Superintendent of some County Board of Public Education, attesting the fact that he is possessed of at least the educational attainments required of second grade teachers of public schools. Provided however, that if a student so applying is unable to furnish the above and foregoing evidence of literary qualifications, he may be permitted to matriculate and receive medical instructions as other students, and qualify himself in the required literary departments, and stand his required examinations as above specified, prior to offering himself for a second course of lectures.

The foregoing diploma or certificate of educational qualifications, attested by the Dean of the Medical College attended, together with a set of tickets showing that the holder has attended one full course of medical lectures, shall be essential to attendance upon a second course of lectures in any college belonging to this Association.

#### BRANCHES OF MEDICAL SCIENCE TO BE INCLUDED IN COURSE OF INSTRUCTION.

Anatomy, Physiology, Chemistry, Materia Medica and Therapeutics, Theory and Practice of Medicine, Pathology, Surgery, Obstetrics and Gynecology, Hygiene, Medical Jurisprudence (Forensic Medi-

cine) and special Laboratory work as hereinafter provided.

#### QUALIFICATIONS FOR GRADUATION.

Candidates for graduation in addition to the usual requirements of Medical Colleges, must have attended three courses of lectures of not less than six months each in three separate years:

Must have dissected in two courses, and attended two courses of clinical or hospital instructions.

And must have attended one course in each of the special Laboratory departments to wit:

1. Histology and Bacteriology.
2. Chemistry.
3. Operative Surgery.

These requirements shall not apply to any student who has received a course of medical lectures prior to September 1, 1892.

M. T. BRIGGS, }  
J. B. MARVIN, } Committee.  
J. S. CAIN. }

The ..... of ..... agrees to the above regulations and thereby becomes a member.

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.....

#### CHRISTOPHER (W. S.) ON RETAINED FÆCES.

The following conclusions are submitted:

1. Long continued partial retention of fæces is common.
2. Such retention is usually harmless.
3. Retained fæces undergoing putrefaction may, at any time, acquire poisonous properties.
4. Retained fæces may produce either local or constitutional symptoms.
5. The principal local conditions produced by retained fæces are typhlitis, appendicitis, and peritonitis, either localized or general.
6. Retained fæces, through the poisons produced in them, are capable of causing any constitutional symptoms which can be manifested through the agency of the central nervous system.
7. Among the toxic effects of such stercoræmia may be mentioned fever, convulsions, coma, insomnia, headache, neuralgia, vertigo, anæmia, diarrhœa, constipation, incontinence of urine and fæces, insanity, etc.—*Journal American Medical Association.*

## Translations.\*

By MARIE B. WERNER, M. D.

Dr. J. G. Master of Kiew, (*Jahrbuch f. Kinderheil* 34, 1892.) earnestly recommends the use of phosphorus for rachitis coincident nervous phenomena, he prefers the oil of sweet almonds rather than Cod Liver oil as a menstruum.

**R** Ol. Phosphorat offic. (1:80)..... gtts. x.  
 Ol. Amygdalæ dulc. .... 15  
 M. Sig.—10 drops once or twice daily for children of 2 to 3 years.

Dr. Karl Gebb (*Inaug. diss. Würzburg, 1892*) presents the clinical history of 21 patients suffering from benign neoplasms of the larynx, observed by him at different clinics.

Seven cases of fibroma; these were usually isolated and located on the free border of the vocal cords, between their anterior and middle thirds—the age of the patients ranged between 24 to 48 years.

In 9 patients aged respectively between 10 to 64 years cysts were observed on the epiglottis, the arytenoid and pharyngo-epiglottidean folds and the vocal cords. In only two of these cases, hoarseness as a symptom, led the physician to make a local examination, the other were casually found in making examinations. Angioma was found once, in a man of 65 years who had been hoarse for one and one-half years previously. It was located in the R. sinus morgagni.

Four cases of papilloma (in two men and two children.) One of the children died shortly after tracheotomy had been performed from pneumonia.

In the three other cases numerous returns were observed after removal by either the endolaryngeal method or by the laryngo fissure.

Falkenheim and M. Askanazy (*Jahrbuch f. Kinderheil* 34, 1892) reports a case of perforative peritonitis in the newborn with calcareous degeneration of the extravasated meconium. The child born by the breech, with subsequent extraction of the head, showed marked tympanitic distension of the abdomen. A puncture made five days after birth was followed by the escape of large quantities of gas,

affording temporary relief but cyanosis and death occurred on the twenty-third day. The most prominent symptoms were vomiting and eructations but apparently no abdominal tenderness.

Post-mortem examination revealed a large quantity of gas in the abdominal cavity, the peritoneum was covered with a fibrinous coating undergoing suppurative changes, numerous small nodules were noticed principally in the region of the flexura coli sinistra. At this point the colon presented a funnel-shaped depression having at its deepest point an opening the size of a pin's head. The hard nodules contained calcareous matter. After dissolving these calcified particles examination showed that they contained epithelial cells, cholestrine, bilirubin and isolated hairs, this proved the nodules to consist largely of calcified meconium. The authors deduct from this that the perforation occurred at a time when the intestine contained only meconium, but after birth, the meconium containing bacilli; this he considered to be the cause of the peritonitis.

Von Dübler and Genserich have described similar cases.

Dr. G. Dittrich (*Deutsch Zeitsch f. Chirurg.*, 33, 1891) has contributed an interesting article on the subject of "Statistics of Mammary Cancer."

The material which has furnished subject matter for his studies was derived from the Strassburger Surgical Clinic. During this time 110 cases of mammary carcinoma were seen; 107 among women—three among men. The author received definite answers from eighty-two of these in making his inquiries. Ten died at the hospital and were examined post-mortem.

The ages of the patients ranged mostly between forty-six and fifty years.

As aids to the cause D. recognizes on the one hand the absence of the physiological activity of the gland, or, again an over-stimulation of its functions.

In twelve cases mastitis preceded the malignancy, six times in the gland so affected, five times in both mammae and once in the healthy breast. In ten cases trauma acted as an immediate causative factor. In three cases eczema and fissures were noticed. Six patients gave a distinct history of heredity.

\*Translated for MEDICAL AND SURGICAL REPORTER.

Anatomico-pathological investigations proved the scirrhus variety the most frequent.

In seventy-eight cases the integument was infiltrated and involved; only in seventeen the skin remained free. In seventy-one females the axillary glands were found infiltrated; in twenty-four they were intact. The tumor was adherent to the pectoralis major in twelve cases and in eighteen its surface was ulcerating.

In ninety-eight cases the total amputation of the mamma and thorough clearing of the axillary space was practiced—only twice was the tumor alone removed, both live still, one eight years, the other five and a half years since the operation, with no signs of return. Five patients were inoperable. The returns which presented themselves after the operation were removed in thirteen patients.

Of the 104 operated cases, there were eight deaths. Of the ninety-five discharged cured, eighty answered the written communication;  $23=28.7$  per cent. were still alive. Thirteen can be regarded as cured, 16.3 per cent., by this the author means no return since within the space of three years. In nine of these, four to ten and a half years have elapsed since the operation.

Of the three male patients, one died of erysipelas; one died two and a half years after operation of pneumonia; one had a return which was removed, the patient was then lost sight of

"A Contribution to Internal Surgery," by Prof. Edin Rose (*Deutsch Zeitsch. f. Chir.* 34, 1892). The author has for the space of nearly 30 years, studied the question of symptoms of rupture of the stomach as a result of gunshot wounds, and internal injuries.

In the last two years Rose has had the opportunity of performing celiotomy in two patients suffering from such an injury and presents now the interesting history of his patients.

Male, æt. 20, fell from the roof of a three-story house and sustained a severe concussion of the brain and fracture of the skull together with other injuries. He vomited twelve times dark colored blood during the first two days.

The abdomen was much distended, sensitive laterally and dull on percussion. Rose thought of possible rupture of the

intestines, but desisted from performing an operation because the patient was unconscious and later because there was a normal discharge of natural colored feces. The patient was discharged after two months, apparently in good health, but returned a month later suffering from ileus. A mechanical obstruction seemed to be the cause and Rose advised laparotomy. An abscess of the liver was found occupying almost the entire left lobe, adherent to the stomach and indirectly to the transverse colon—the increase of this abscess formed the stenosis from which the patient was suffering, its evacuation and fastening the abscess walls to the incisions, resulted in recovery.

Second case: The patient, aged 24 years, was thrown out of a freight car, and fell with his left side upon the sharp edge of a board fence. Vomiting the contents of stomach mixed with blood, at once set in, and was promptly followed by vomiting of clear blood. One finger's breadth above the umbilicus could be seen or felt a depression, above this the abdomen was seen bulging forward containing liver, spleen and stomach, but in this swelling their outline could not be distinguished by the percussion note. On the 14th day, a section was performed and a rupture of the pancreas and posterior wall of the stomach. Through the rupture of the stomach the remainder of its contents had entered between the omental layer, making a tumor between the pancreas and stomach. The blood and pancreatic juice aided to produce an inflammation in this sac, by which the foramen of Winslow was closed. This case also recovered.

These two cases have taught the author to regard the continued vomiting of blood after injuries from a previously healthy stomach, as a pathognomonic symptom of rupture of the stomach.

Injuries to large venous trunks treated by lateral closure. Dr. Niebergall, of Marburg (*Deutsch Zeitsch. f. Chirurg.*, 23, 1892). The various methods taught at Kuster's clinic, for the arrest of hæmorrhage in injuries to large venous trunks are: first, *compression*, sometimes *tampon*. Second, *lateral ligature*. Third, *suturing the vein*. Fourth, *lateral compression by means of forceps temporarily left in situ*. The experience of Niebergall by compression or tamponing in minor injuries to

venous trunks is, that this method often produces union minus any great reduction in the calibre of the vessel. More extensive injuries however require a different course of treatment, since there is little hope of retaining its lumen, as well as the possibility of non-arrest of hæmorrhage; this is especially true of such veins as the femoral where the collateral circulation is not so fully developed.

In bleeding from eroded veins the antiseptic tampon may prove of service.

*Lateral ligature* has proved successful in Niebergall's hands with, however, some diminution of the lumen of the vessel at the space ligated which increased in direct ratio to the amount of venous wall enclosed in the ligature. The objections to this method are: primary hæmorrhage due to the ligature slipping, this is often prompted by an unavoidable shortening of the vein in its ligation, this danger is less when the wound has occurred at a place where another vein joins it. Any abnormal or pathological changes of the walls of the veins, frequently favor the cutting through of the ligature.

*Suture of the vein.* Niebergall reports ten cases collected from medical literature. From these he forms the following conclusions: This method is peculiarly adapted to injuries in the long or transverse axis of the vessel, and the results have been superior to those of the former method, since there is less danger of primary hæmorrhage, and the lumen of the vessel is not so much diminished, the adaption of the wounded edges promises better and more lasting results. Two important points must enter into the consideration for the use of this method, in order to attain the above results, i. e., antiseptics, and healthy venous walls.

*Lateral and total compression by means of forceps left in situ:*—Niebergall reports fifty-three cases, and gives the following conclusions: This method is thoroughly reliable and in the presence of strict antiseptics, gentle and careful removal of the forceps after twenty-four hours, secondary hæmorrhage seldom, if ever, occurs; the lumen of the vessel is retained, since the forceps favor adhesive union of the inner coat, which is of sufficient firmness to hold until complete cicatrization has taken place, this usually occurs in about fourteen days. The author prefers to use Pean's forceps.

Dr. Passet, of Munich, (*Munch. Med. Woch.* No. 32, 1892) presents under the head of, "Legal Responsibility of the Physician Administering Chloroform or Other Anæsthetics," the following rules for its safe administration, based upon his own experience and that of others: (1) A thorough knowledge of the general health, condition of the circulatory and respiratory organs is imperative. The urine should be examined. An injection of morphia should precede operations of longer duration. This will diminish the quantity of chloroform necessary. In organic disease of the heart, a combination of ether and chloroform, or ether is to be preferred, and lastly, local anæsthesia is to be preferred in smaller operations,—the use of bromide of ethyl; (2) in cases where grave changes are present in the circulatory or respiratory organs, or if asphyxia is present through obstruction in the air-passages, anæsthesia is not admissible; (3) chloroform should never be administered during digestion; artificial teeth should be removed; the patient placed on his back during the early stage of narcosis, to be changed later as needed; (4) only chemically pure chloroform should be used; (5) chloroform should always be given with sufficient air; it should be used in drop doses; any apparatus which combines chloroform with a proper amount of air is to be recommended; (6) during the operation it is imperative to watch the circulation and respiration. If possible the pulse should be recorded by an assistant; arrest of heart's action, or asphyxia must be treated promptly; (7) when complete narcosis has set in, small quantities at longer intervals are indicated.

The physician can only be held responsible for untoward results if any of the above directions have been overlooked.

Kronfeld reports a case of poisoning by antifebrin taken with suicidal intent. (*Wiener Med. Woch.*, No. 38, 1892) Male; æt. twenty-four; swallowed twelve grammes at one dose. He at once became drowsy, and soon marked cyanosis set in. Injections of ether and lavage of the stomach with cold water revived the patient, and in a few days he recovered. The antifebrin was eliminated chiefly in the urine. The temperature was persistently low.

## Abstracts.

### TUBAL MOLES.

In the *Lancet*, November 12th, Dr. Bland Sutton, of London, gives an interesting illustrated article upon this subject. He says, in part:

Tubal moles differ from uterine moles in several particulars—indeed the points are such as to enable us readily to tell one from the other.

The uterine mole is more or less spherical; the amniotic cavity is of fair size and occupies the center of the mole. The embryo may, or may not, be present. Sometimes it is represented merely by an ill-shaped mass pendulous at the end of the cord. Even when the embryo can be recognized it is very misshapen, and the umbilical cord is often oedematous.

A tubal mole in its early stage is spherical, but, after attaining the dimensions of a walnut, becomes ovoid. In the majority of cases the amniotic cavity occupies an excentric position. In consequence of this peculiarity the thin amnion is easily ruptured and permits the escape of the embryo. This explains the difficulty of finding the embryo in many cases where the mole has been discharged through the rent in the wall of the tube or aborted through an unclosed ostium, accompanied, as the rule is in these cases, with free hæmorrhage. The mole is easily found in the clot, but if the embryo has escaped from the amniotic cavity the chances are that it will not be recognized. It must not be imagined that because the embryo has not been found it has been dissolved by the peritoneum. On one occasion I collected all the blood and clot which I removed during an operation five weeks after the rupture of a gravid tube, and disintegrated it by a gentle stream of water. In the course of this manœuvre the embryo came to the surface, was recognized and caught. As is the case with uterine moles, the embryo sometimes dies very early, and the amniotic sac contains nothing but a small quantity of fluid. When the mole, on its escape from the tube, is discharged between the layers of the broad ligament it becomes so compressed that the embryo is found flattened out like a succulent flower firmly squeezed between the layers of a heavy book.

It will be necessary to offer a few remarks on the recognition of a tubal mole. When a mole is found with an embryo in the amniotic cavity there cannot be any room for dispute. The same holds good for moles with amniotic cavity, though no embryo is present. In hard firm clots in which the amniotic cavity is not recognizable, sections from the supposed mole must be prepared and examined with a microscope for chorionic villi. The presence of chorionic villi are as indicative of a mole as of the presence of an embryo. These villi are such characteristic structures that they cannot be confounded with "half-organized blood," as some writers have suggested.

It is of great importance to appreciate clearly the character of a tubal mole, for the presence of a mole is decisive proof of pregnancy.

It will, perhaps, be useful to offer a few remarks on decidua. When a fallopian tube becomes gravid a decidua forms in the uterus, and this curious structure has a diagnostic value. This decidua is rarely retained until the completion of gestation and thrown off during the false labor. Usually it is discharged during the early period of pregnancy in small fragments, without producing pain, or else it is expelled *en masse* with symptoms of miscarriage. When a gravid tube ruptures or aborts, the uterus becomes disturbed and the decidua is expelled. When a decidua is expelled whole it represents a cast of the uterine cavity. It is in shape pyramidal; the base corresponds to the fundus of the uterus, and at each angle there is an orifice corresponding to the uterine opening of each fallopian tube. The apex of the pyramid is occupied by a circular hole, corresponding with the dilated internal orifice of the cervical canal. This is smooth and rounded, whilst the smaller orifices corresponding to the uterine ends of the tubes are ragged. The exterior of the decidua is shaggy, the interior smooth and dotted with many minute puncta, representing the orifices of the uterine glands.

There is little doubt that the majority of cases formerly classed as pelvic hæmatoceles are in reality the result of rupture or abortion of gravid tubes. The cases in which doubts arise are those in which women are seized with symptoms indicating internal hæmorrhage. On opening

the abdomen free blood is found, often in abundance. The tube is widely dilated, perhaps ruptured, and clots of blood hang about the fringes, yet no embryo is detected. In some of these cases a decidua is discharged from the uterus. These doubtful cases will become fewer as operators become familiar with the tubal mole. The mole is so different from ordinary clot that there should be little difficulty in distinguishing it, except in cases in which it is very small.

The following is a summary of the views contained in this paper: (1) The transformation of a tubal ovum into a mole or apoplectic ovum is beyond doubt; (2) the majority of specimens described as examples of hæmato-salpinx are gravid tubes; (3) rupture of a gravid tube and tubal abortion are the common causes of pelvic hæmatocele; (4) mesometric rupture of a gravid tube is a common cause of pelvic hæmatoma; (5) to affirm that bands of fibrin resemble chorionic villi indicates great want of histological knowledge; (6) every clot of blood found in a fallopian tube is not a tubal mole.

Since the discovery of the tubal mole, specimens of non-gravid fallopian tubes are found to be so infrequent that in the last report of the museum of the Royal College of Surgeons I notice an account of "an unequivocal example of hæmato-salpinx." This is a fair indication of the revolution which has taken place in our knowledge of the early stages of tubal pregnancy.

#### TREATMENT OF ANEURISM AND OF HÆMORRHOIDS, BY HYPODERMIC INJECTIONS OF BLOOD CLOT.

Dr. G. K. Turner, in a paper read before the East Tennessee Medical Society, thinks that this method gives promise of great usefulness.

"As there is no possible method for treating aneurisms that does not involve either clotting of the blood in the aneurism sac or obliteration of the artery, there can be no valid objection to clotting blood outside of the artery and then introducing it, where required, by hypodermic syringe."

His plan is, after thorough asepsis, to draw blood from patient's arm, or from the arm of a friend, and clot this blood,

or allow it to do so spontaneously. Then strain off the serum and inject at the distal side of the aneurism, first deadening the skin with a four per cent. solution of cocaine. He recommends that the current of blood in the artery be checked by tourniquet or manual pressure beforehand, and the aneurism filled at one injection.

He also proposes the same clot injection for hæmorrhoids in place of using astringents or carbolic acid, which do no more than produce a clot. "Why not use a clot at first hand."

#### A CASE OF GOITRE CURED BY GALVANISM AND SYRUP OF HYDRIODIC ACID.

Dr. W. C. Wile reports in Nov. No. of the *New England Medical Monthly* a case of goitre which recovered in eight months, under treatment.

The patient, a lady; æt. thirty-seven, mother of four children, had a severe attack of LaGrippe followed by pneumonia. Convalescence was long and tedious. She then noticed palpitation of heart, indigestion, insomnia and extreme nervousness. A careful examination revealed no organic heart disease, but it was found that all of her symptoms were due to a commencing Graves' disease.

She had the enlargement of the thyroid gland, exophthalmia, and all of the nervous phenomena.

The bowels were regulated, and patient given a plain nourishing diet, including sherry wine, sulphonal was given for insomnia.

From eight to ten cells of the galvanic current were administered, placing the positive pole inside the left ear, and the negative over the seventh cervical vertebra applying the current for twenty minutes, each day. Internally, she was given syrup of hydriodic acid, in teaspoonful doses, t. i. d., which was gradually increased, until two tablespoonfuls were taken at one time, t. i. d. Then the dose was reduced, to the original teaspoonful, which she continued taking for seven months.

Improvement was immediate and rapid. The galvanism was stopped at the end of the month, while the syrup of hydriodic acid was continued.

She was discharged perfectly cured.

## Selected Formulæ.

## TREATMENT OF CARDIAC ASTHMA.

Dr. Ferrand (*Le Bulletin médical*), recommends the following treatment:

## General treatment:

1. Each morning two soup-spoonfuls of:

|          |                                |            |
|----------|--------------------------------|------------|
| <b>R</b> | Iodide of sodium.....          | 25 grams.  |
|          | ( <i>℥</i> ʒj).                |            |
|          | Infusion of elder flowers..... | 300 grams. |
|          | ( <i>℥</i> 3x).                |            |

2. Every evening, before eating, two soup-spoonfuls of:

|          |                        |            |
|----------|------------------------|------------|
| <b>R</b> | Bromide of sodium..... | 25 grams.  |
|          | ( <i>℥</i> ʒj).        |            |
|          | Syrup of aconite.....  | 50 grams.  |
|          | ( <i>℥</i> 3jss).      |            |
|          | Infusion of hops.....  | 250 grams. |
|          | ( <i>℥</i> ʒviij).     |            |

## Treatment of the crisis:

1. Place the hands in a dish of hot water.  
2. Give inhalations of ammonia.  
3. Give every five or ten minutes five drops of:

|          |                          |          |
|----------|--------------------------|----------|
| <b>R</b> | Laudanum.....            | 4 grams. |
|          | ( <i>℥</i> 3j).          |          |
|          | Cherry laurel water..... | 6 grams. |
|          | ( <i>℥</i> 3jss).        |          |

4. Inject subcutaneously the following:

|          |                          |          |
|----------|--------------------------|----------|
| <b>R</b> | Atropine sulphate.....   | cgms. 1  |
|          | ( <i>gr.</i> 1-8th).     |          |
|          | Morphine sulphate.....   | cgms. 2  |
|          | ( <i>gr.</i> ʒj).        |          |
|          | Cherry laurel water..... | cgms. 10 |
|          | ( <i>℥</i> ʒijss).       |          |

During the intervals one may employ the following means:

Administer each day before the two principal meals a spoonful of:

|          |                          |            |
|----------|--------------------------|------------|
| <b>R</b> | Iodide of potash.....    | 20 grams.  |
|          | ( <i>℥</i> ʒv).          |            |
|          | Syrup of capillaire..... | 125 grams. |
|          | ( <i>℥</i> ʒiv).         |            |

Morning and evening take one of the following pills:

|          |   |         |
|----------|---|---------|
| <b>R</b> | Ext. of stramonium, } <i>ss</i>           | cgms. 1 |
|          | Valerianate of zinc, } ( <i>gr.</i> 1-5). |         |
|          | Sufficient for one pill.                  |         |

Every two days take:

|          |                         |           |
|----------|-------------------------|-----------|
| <b>R</b> | Syrup of buckthorn..... | 30 grams. |
|          | ( <i>℥</i> ʒj).         |           |

—*Lan. Clin.*

## FOR PRURITUS ANI.

An ointment containing:

|          |                               |           |
|----------|-------------------------------|-----------|
| <b>R</b> | Cresote or carbolic acid..... | 1 dram.   |
|          | Lard.....                     | 2 ounces. |
|          | Camphor.....                  | 1 dram.   |

Applied topically, is a safe and often effectual remedy for the relief of pruritus ani.—*News.*

## ACUTE CORYZA.

Dr. Capitan recommends the following snuff to be used every hour for the relief of acute nasal catarrh:

|          |                     |             |
|----------|---------------------|-------------|
| <b>R</b> | Salol.....          | ʒ ss.       |
|          | Salicylic acid..... | ʒj. grains. |
|          | Tannin.....         | ℥j. grains. |
|          | Boric acid.....     | ʒ ij.       |

The use of this powder should not be continued for more than a few hours, as it is apt to excite a slight eczematous eruption along the edges of the nostrils. The following is another formula, less active, yet said to have given good results:

|          |                      |             |
|----------|----------------------|-------------|
| <b>R</b> | Powdered talc.....   | ʒj.         |
|          | Antipyrin.....       | xv. grains. |
|          | Boric acid.....      | ʒ ss.       |
|          | Salicylate acid..... | iv. grains. |

This may be snuffed freely, as it causes no irritation of the *alæ nasi* as does the preceding.—*Jour. de Méd. et Chir. Prat.*

## TREATMENT OF ACUTE BRONCHITIS.

Simple cases usually recover (Dr. Canfield, *Therap. Gazette*) under the use of a good expectorant mixture, such as:

|          |  |         |
|----------|--|---------|
| <b>R</b> | Ammon. muriat.....                             | ʒss     |
|          | Mist. glycyrrhiz. co.....                      | ʒiv. M. |
|          | Sig.—Desertspoonful every three or four hours. |         |

When the secretions are abundant, and not easily coughed up, a turpentine emulsion is excellent. For instance:

|          |   |              |
|----------|---|--------------|
| <b>R</b> | Ol. terebinth.....                            | ʒij to ʒiij. |
|          | Muc. acacie.....                              | q. s.        |
|          | Aq. cinnamon.....                             | ʒi.          |
|          | Aque. q. s. ad.....                           | ʒvj. M.      |
|          | Sig.—Tablespoonful in water every four hours. |              |

Sometimes the cough is of such an irritating character that expectorant measures avail little. Some narcotic must then be used. Codeine has not the disadvantages of morphine, and is efficient. A good combination is:

|          |  |           |
|----------|--|-----------|
| <b>R</b> | Codeine sulphat.....   | gr. viij. |
|          | Syr. prun. virgin.....   | ʒviij. M. |
|          | Sig.—Tablespoonful in water three or four times per day, and at bed-time if necessary. |           |

## TREATMENT OF BALDNESS.

One of the best combinations in the treatment of baldness consists of:

|          |                                 |         |
|----------|---------------------------------|---------|
| <b>R</b> | Pilocarpine hydrochloratis..... | gr. v.  |
|          | Oil of rose.....                | m viij. |
|          | Oil of rosmarini.....           | ʒ ʒiv.  |
|          | Liniment cantharidis.....       | ʒ ʒiv.  |
|          | Glycerin puri.....              | ʒ ʒj.   |
|          | Oil amygdale dulcis.....        | ʒ ʒj.   |
|          | Spiritus camphore.....          | ʒ ʒj.   |

M. S.: To be rubbed well into the scalp, night and morning.

—Whitla, *Ther. Rev.*

## Book Reviews.

*Die Mikroorganismen der Mundhöhle.* Die örtlichen und allgemeinen Erkrankungen, welche durch dieselben hervorgerufen werden. By W. D. Miller. Geo. Thieme, Leipzig, 1892. Second Edition, 440 pages, 134 figures and 18 photograms. 12 marks (\$3.00).

The fact that this work ran through its first edition in two years time speaks very well both for the book itself and for the author, who is one of the few Americans called to fill professors' chairs in German universities.

The first part of the work contains a general discussion of bacteriology; the nourishment which bacteria find in the mouth; an historical review of bacteriology as applied to dentistry; methods of preparing cultures, etc.; fermentation caused by bacteria found in the mouth; influence of the fermentation upon different parts of the mouth; caries of the teeth, including both historical review and original investigations upon the same; and asepsis and antisepsis in dentistry. The second part of the book contains an excellent discussion of the pathogenic bacteria found in the mouth.

The entire work is excellently illustrated and will be of value to the practicing dentist as well as to the bacteriologist. We recommend this work to all our dental friends.

*A Public Scandal. Inoculation a Preventative of Swine Plague with the Demonstration that the Administration of the Agricultural Department is a Public Scandal. An Exposure by F. S. Billings.*

This pamphlet of over 300 pages consists chiefly of a review of Dr. Billings' charges against Dr. Salmon, Chief of the Bureau of Animal Industry, together with charges of treason against Secretary Rusk of the Department of Agriculture, and a personal estimate of his own (Billings) ability and the value of his scientific investigations.

We do not think Secretary Rusk will be tried for treason on account of the charges made against him by the writer, namely: That he (Secretary Rusk) has continued to doubt the value of Billings' methods and has allowed himself to be duped by Salmon. Nor do we believe that the eminent Chief of the Bureau is going to suffer any from attacks made in such manner and in such language.

Some of the statements made are too good to leave unmentioned.

On page 21, the Nebraska bacteriologist asks, referring to himself, "Is there a better man for this work to be found, not only in this country but in the world to-day? Virchow is my only master."

The chapters in which charges of treason are brought against Uncle Jerry Rusk and which discuss "The causes which have led to the conditions here portrayed in American politics" are amusing and in entire keeping with the rest of the book.

Dr. Billings' imagines that Secretary Rusk has spies placed around the Nebraska Laboratory; that the Department of Agriculture stands in great fear of his exposures and that he himself is a modern martyr. His entire book immediately suggests the idea that the author is in an excited, nervous and unhealthy state of mind.

## BOOKS RECEIVED.

[In sending books for notice in the *REPORTER*, publishers are requested, for the information of the reader, as well as for their own advantage, to give the price. This announcement by title will be followed, in most cases, by a review, which will appear at the earliest opportunity.]

*An American Text-Book of Surgery for Practitioners and Students.* Edited by W. W. Keen, M. D., LL. D. Philadelphia: W. B. Saunders, 913 Walnut St., and J. W. White, M. D., Ph. D.

*International Clinics.* A Quarterly of Clinical Lectures on Medicine, Surgery, Gynecology, Pediatrics, Neurology, Dermatology, Laryngology, Ophthalmology, and Otology, by Professors and Lecturers in the Leading Medical Colleges of the United States, Great Britain and Canada. Edited by John M. Keating, M. D., J. P. Crozer Griffith, M. D., J. M. Mitchell Bruce, M. D., F. R. C. P. and David W. Findlay, M. D., F. R. C. P. Vols. III, Oct. '91 and IV, Jan., 1892, 8vo., pp. 372. Philadelphia: J. B. Lippincott Company, 1892.

*A Treatise on Diseases of the Rectum, Anus, and Sigmoid Flexure.* By Joseph M. Matthews, M. D., Professor of Principles and Practice of Surgery, etc., Kentucky School of Medicine. New York: D. Appleton & Company, 1892.

*Mother and Child—Part I. Mother.* By Edward P. Davis, A. M., M. D. Part II. *Child.* By John M. Keating, M. D., LL. D. Philadelphia: J. B. Lippincott Co. London: 10 Henrietta Street, Convent Garden, 1893. Price \$2.50.

*A Manual of the Practice of Medicine, Prepared Especially for Students.* By A. A. Stevens, A. M., M. D., Instructor of Physical Diagnosis in the University of Penna., etc. Philadelphia: W. B. Saunders, 913 Walnut Street, 1893. Price \$2.50.

*THE STUDENTS' QUIS SERIES. Diseases of the Eye, Ear, Throat, and Nose.* A Manual for Students and Practitioners, by Frank E. Miller, M. D., James P. McEvoy, M. D., and John E. Weeks, M. D. Series edited by Bern B. Gallaudet, M. D. Philadelphia: Lea Brothers & Co. Price \$1.00.

*Transactions of the American Otological Society. Twenty-fifth Annual Meeting, Fort Griswold House, New London, Conn., July 19, 1892. Volume V., Part II. Published by the Society, 1892.*

*Proceedings of the Fourth State Sanitary Convention of Pennsylvania. Held at Norristown, May 9, and 10, 1890. Harrisburg, Pa.: Edwin K. Meyers, State Printer, 1891.*

*Local Boards of Health in the State of New York. Albany: Weed Parsons & Company, Printers, 1892.*

*Annual Report Philadelphia Bureau of Health, 1891.*

*One Thousand Prescriptions or Favorite Formulae of Various Authors, Teachers and Practicing Physicians. The whole being very carefully indexed and including most of the newer remedies. Price \$1.00. Published by the Illustrated Medical Journal Co., Detroit, Mich.*

*Physician's Pocket Diary. For 1893. Any physician who has not received a copy of the McArthur Diary for 1893, will receive one on application, without expense. McArthur' Hypophosphite Co., Ansonia, Conn.*

*The Physicians Visiting-List, 1893. Lindsay & Blakiston's. Forty-second year of publication. Philadelphia: P. Blakiston, Son & Co. 1012 Walnut Street. Price \$1.00.*

## NEWS AND MISCELLANY.

### NATIONAL ASSOCIATION OF RAILWAY SURGEONS.

#### SIXTH ANNUAL MEETING.

Preliminary announcement of the special program of the sixth annual meeting of the National Association of Railway Surgeons, embracing the United States of America, the Dominion of Canada and the Republic of Mexico, to be held at Omaha, Neb., the last Wednesday, Thursday and Friday of May, 1893. General subject:—"Injuries of the Cord and its Envelopes Without Fracture of the Spine."

1st. History, by Dr. Geo. Ross, Chief Surgeon Richmond & Danville R. R., Richmond, Va.

2d. Anatomical Landmarks, by Dr. Jabez N. Jackson, Surgeon Wabash R. R., Kansas City, Mo.

3d. Physiology of the Spinal Cord, by Dr. A. P. Grinnell, Chief Surgeon Central Vermont R. R., Burlington, Vt.

4th. Experimental Research, by Dr. B. A. Watson, Surgeon Pennsylvania R. R., Jersey City, N. J.

5th. An Experimental Study of Spinal Myelitis and Meningitis, by Dr. Geo. A. Baxter, Div. Surg. Chattanooga Southern R. R., Chattanooga, Tenn.

6th. The Clinical Aspects of Spinal Localization, by Dr. Nicholas Senn, Surgeon Chicago, St. Paul & Kansas City R. R., Chicago, Ill.

7th. Diagnosis from the standpoint of the Neurologist, by Dr. C. H. Hughes, Consulting Surgeon Missouri Pacific R. R., St. Louis, Mo.

8th. Pathology and Pathological Anatomy, by Dr. Samuel C. Benedict, Surgeon Richmond & Danville R. R., Athens, Ga.

9th. Prognosis, by Dr. Samuel S. Thorn, Chief Surgeon, Toledo, St. Louis & Kansas City, R. R., Toledo, Ohio.

10th. Treatment, by Dr. W. B. Outten, Chief Surgeon Missouri Pacific R. R., St. Louis, Mo.

11th. Medico-Legal Aspects, by Judge J. H. Collins, Chief Counsel Balto. & Ohio R. R., West of the Ohio river, Columbus, Ohio.

12th. Statistics of the Amount of Money paid by the Railroads of the United States, During the last Ten Years, for Alleged Injuries of the Spine, by Dr. F. K. Ainsworth, Surgeon Southern Pacific R. R., Los Angeles, California.

13th. Clinical Report—1st, From a Medical Aspect—(a) Permanent Injuries—(b) Alleged Injuries. 2d, From a Legal Aspect—(a) Settled with Suit—(b) Settled Without Suit—(c) Miscellaneous, by Dr. Geo. Chaffee, Surgeon Long Island R. R., Brooklyn, N. Y.

C. W. P. BROCK, M. D. Pres't.  
Richmond, Va.

E. R. LEWIS, M. D., Sec'y.  
Kansas City, Mo.

### OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY FROM DECEMBER 4, 1892, TO DECEMBER 10, 1892.

War Department, Washington City, December 5th, 1892. By direction of the President the retirement from active service on Dec. 4th, 1892, by operation of law, of Colonel Anthony Heger, assistant surgeon, under the provisions of the act of Congress approved June 30th, 1892, is announced, and he will proceed to his home.

By par. 6. S. O. 286, A. G. O. the leave of absence on surgeon's certificate of disability granted Mayor J. C. G. Happersett, surgeon, in S. O. 178, Nov. 18th, 1892, Dept. Dak., is extended three months on surgeon's certificate of disability.